U.S. DEPARTMENT OF
HEALTH AND HUMAN
SERVICES

HCFA
Health Care Financing Administration

A Profile of Medicare Home Health

CHART BOOK

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Health Care Financing Administration

Acknowledgements

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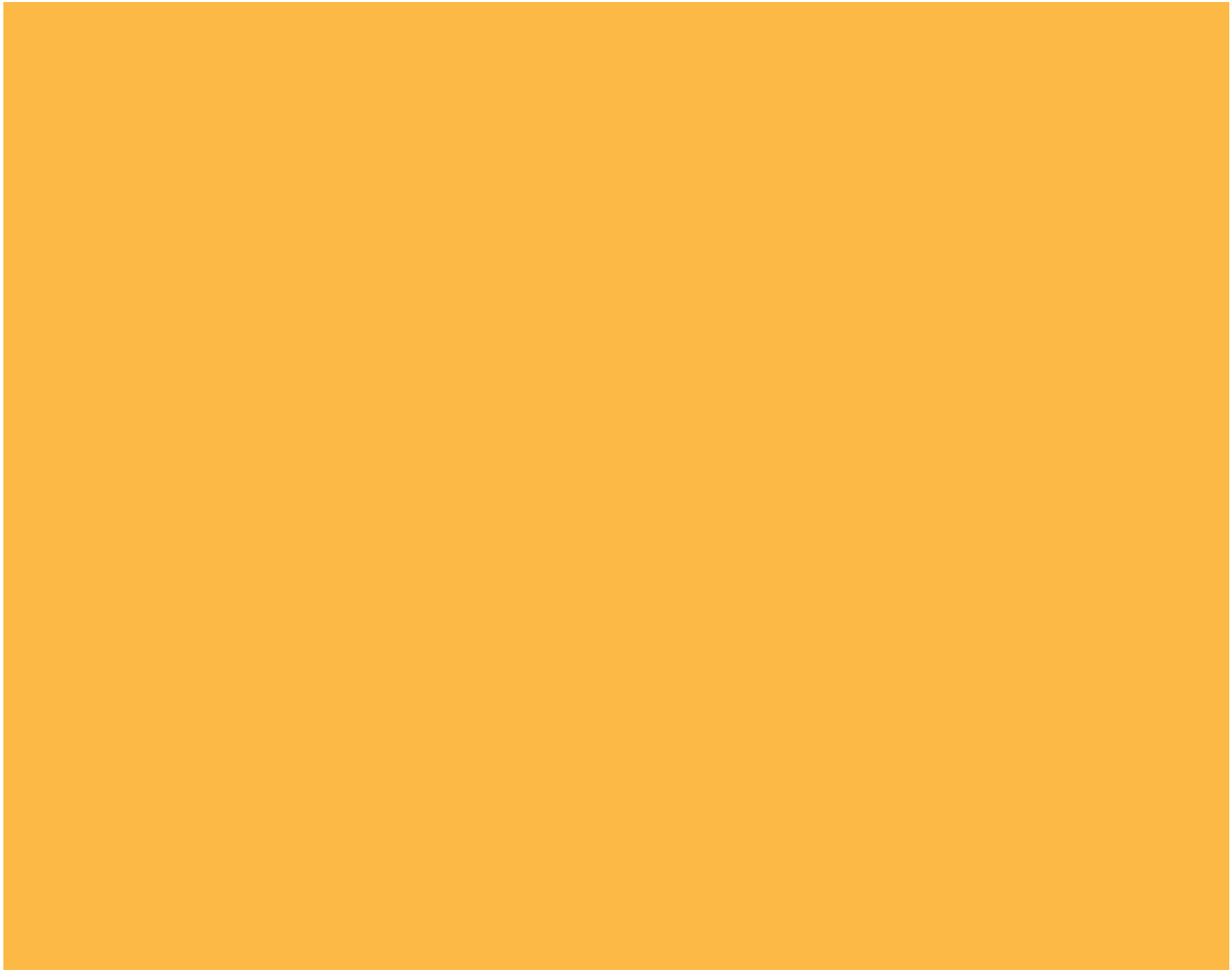

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Preface

On behalf of the Health Care Financing Administration, I am pleased to present *A Profile of Medicare Home Health.* The Medicare home health benefit is crucial to the nearly 4 million beneficiaries who receive care at home. These services greatly improve their quality of life. The benefit helps many patients recuperate in their homes following a hospital or a nursing home stay. For others, the benefit allows sophisticated medical treatments that were once only possible in a hospital setting to be delivered at home.

Since its beginning as part of the Medicare program in 1965, the home health benefit has undergone significant changes. Legislative and judicial reforms expanded Medicare home health over time, permitting sizable increases in utilization, spending, and in the number of providers furnishing services. The home health provisions contained in the bi-partisan Balanced Budget Act of 1997 and the Administration's ongoing fight against waste, fraud and abuse in Medicare are working to ensure that those who are eligible for services receive them, and that Medicare pays for services appropriately.

The chart book provides the facts and figures underlying the changes in the home health benefit. This information is essential as we assess the impact of the Balanced Budget Act, continue to safeguard the benefit for current and future beneficiaries, and as the Nation considers the future of the Medicare program, including home health.

Michael Hash
Deputy Administrator

August 1999

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Profile of Medicare Beneficiaries Who Use Home Health

SECTION 1

1. Profile of Medicare Beneficiaries Who Use Home Health

In general, home health patients tend to be older than the overall Medicare population. They also are more likely to be female, partly due to women's longer life expectancies. Twenty-six percent of home health users are aged 85 or older while only 11 percent of all Medicare beneficiaries are in this age group. Individuals aged 75 to 84 account for nearly 40 percent of all home health patients, compared to 30 percent of the Medicare population as a whole.

As expected with an older population, home health users have relatively high rates of functional impairment. They are more likely to have 3 or more impairments in activities of daily living (ADL)[1] than beneficiaries who do not use home health. Not surprisingly, Medicare spends more on home health users for all services (other than home health) than for non-users. (See Figure 3.6 in the Home Health and Medicare Spending section.) In addition, home health users spend more out-of-pocket for total health care services than non-users, $2,845 and $1,487 respectively.

Home health users are poorer than non-users and are more likely to be dually eligible for Medicare and Medicaid. Among home health users, those with over 100 visits are more likely to have low incomes or have some Medicaid coverage than those with fewer visits.

Home health patients are just as likely to live in metropolitan areas, 73 percent, as beneficiaries who do not use home health, 74 percent, although the average number of visits per user varies between rural and urban areas. (See Figure 2.6 in the Home Health Utilization section.) The racial characteristics of home health users and non-users are relatively similar. Eighty-four percent of users and 86 percent of non-users are white. African Americans comprise 12 percent of the home health patient population and 9 percent of the non-user population.

- **Home Health Use (Figure 1.1).** In 1974, the proportion of beneficiaries using Medicare home health was 1.6 percent. This number grew to 5.1 in 1985, declined to 4.8 in 1987, and then rose again to 5.1 percent in 1989. From 1989 to 1995, the proportion of home health beneficiaries using home health doubled to 10.2 percent. The rapid growth in the number of home health patients is partly due to the court case *Duggan v. Bowen*, settled in 1989, which relaxed the coverage criteria for Medicare home health. (See Section 6, A Medicare Home Health Primer.)

  Since 1995, growth in the percentage of beneficiaries using Medicare home health services has slowed. About 10.8 percent of Medicare beneficiaries used home health services in 1997.

- **Gender (Figure 1.2).** Women are more likely to use Medicare home health services than men. Over two-thirds of home health users are female compared with roughly half of non-users. The longer life expectancy of women may help explain their greater reliance on home health services.

- **Age (Figure 1.3).** Beneficiaries age 85 and older are proportionately the largest users of Medicare home health. About one-quarter of beneficiaries age 85 and older used home health in 1997 compared with almost 15 percent of beneficiaries age 75 to 84, and roughly 6 percent of beneficiaries under age 75.

  While Medicare home health use has increased rapidly across all age groups, the most rapid growth occurred among the youngest (disabled beneficiaries) and oldest beneficiaries — the age groups with the highest prevalence of functional limitations. Between 1987 and 1997, the percent of disabled beneficiaries and those age 85 and older who used home health tripled.

[1] Activities of daily living include eating and bathing, etc.

- **Common Diagnoses (Figure 1.4).** Diabetes is one of the most common diagnoses among home health patients, accounting for 9 percent of all users. Other common diagnoses among home health patients include essential hypertension and heart failure. Among home health users with the most common diagnoses, diabetic patients had the highest average annual home health payment per user, $6,995. The lowest average annual payment was for individuals with other forms of chronic ischemic heart disease, $2,037.

- **Activities of Daily Living (ADLs) (Figures 1.5 and 1.6).** Thirty-nine percent of home health patients have 3 or more impairments in ADLs (e.g., bathing, eating) (Figure 1.5). Only 5 percent of non-home health users have this many ADL limitations. Clearly, home health patients have a higher level of functional impairments compared to the general Medicare population.

  Not surprisingly, Medicare home health users who have more than 100 visits also tend to have a greater number of functional limitations (Figure 1.6). Of the beneficiary group receiving over 100 home health visits, more than two-thirds have 3 or more ADL impairments. In comparison, less than one-third of the beneficiary group with 1 to 100 visits has 3 or more ADL impairments.

- **Living Arrangements (Figure 1.7).** Home health users are more likely to live alone than non-users. About 40 percent of home health patients live alone compared with 30 percent of non-users. Age may partially account for the greater prevalence of home health use among beneficiaries who live alone. Older beneficiaries are more likely to live alone.

- **Income (Figures 1.8 and 1.9).** Home health users are more likely to have low incomes than non-users (Figure 1.8). While less than half of non-users have incomes of $15,000 or less, two-thirds of beneficiaries using home health services have incomes at or below this level. Further, only 14 percent of home health users have incomes in excess of $25,000 compared with 28 percent of non-users. Beneficiaries with low incomes tend to be older than other beneficiaries, which may partly explain their greater likelihood of home health use.

  Of all Medicare home health users, beneficiaries who receive more than 100 home health visits tend to have the lowest income (Figure 1.9). Over three-quarters of these beneficiaries have incomes equal to or less than $15,000. Only 10 percent of this group have incomes above $25,000.

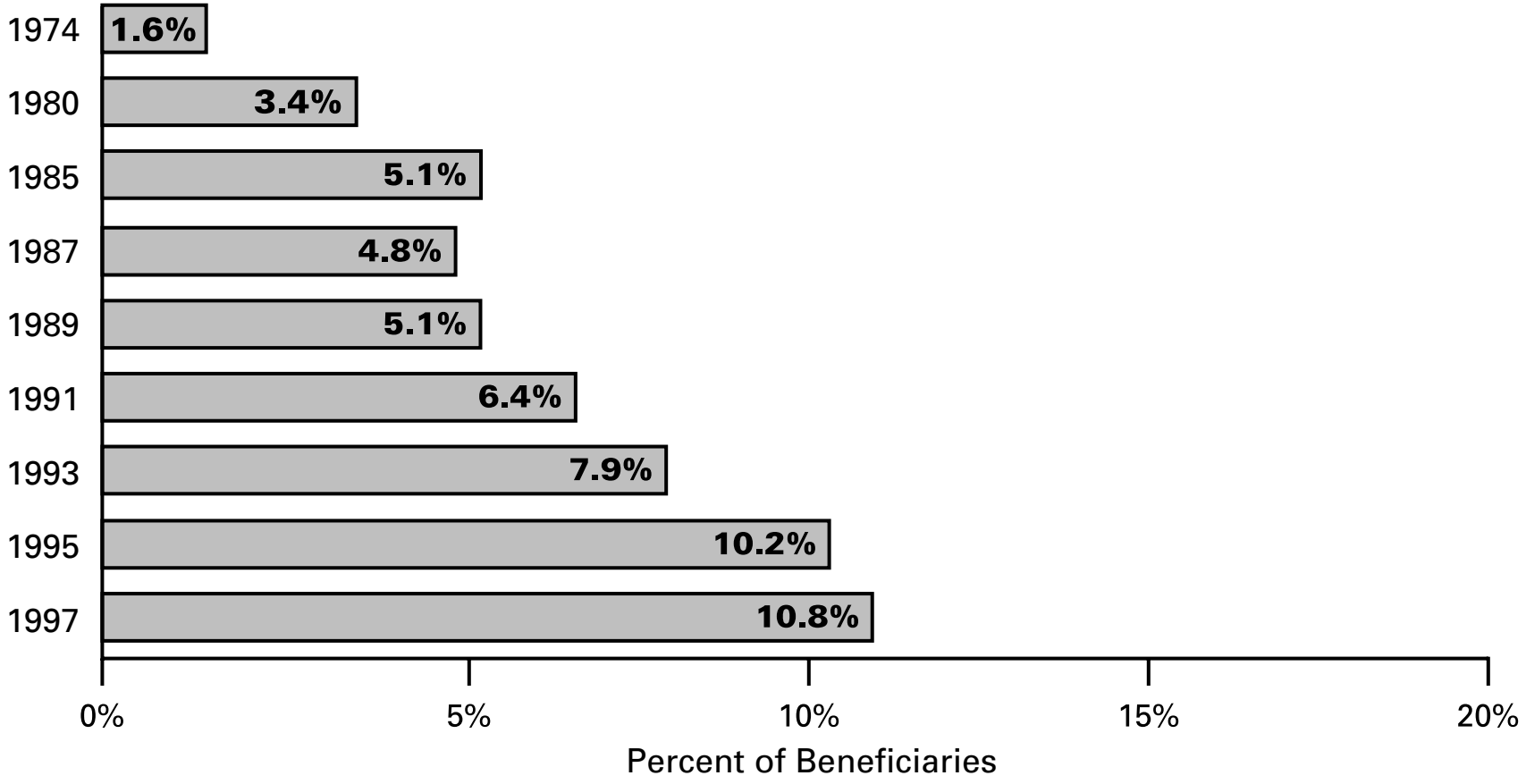
- **Sources of Health Insurance Coverage (Figures 1.10 and 1.11).** While the percent of home health users and non-users with some private health insurance is similar, home health users are more likely to have some Medicaid coverage (Figure 1.10). Beneficiaries with some Medicaid coverage include those who qualify for full Medicaid benefits, and individuals who receive Medicaid assistance in paying Medicare premium and cost-sharing requirements as Qualified Medicare Beneficiaries (QMBs). Individuals who receive Medicare premium assistance as Specified Low-Income Medicare beneficiaries (SLMBs) are also included. Twenty-eight percent of home health patients have some Medicaid coverage. Only 16 percent of non-home health users are receiving Medicaid assistance.

  Home health users with over 100 visits are more likely to receive Medicaid assistance than users with fewer visits (Figure 1.11). About 34 percent of users who receive over 100 visits have some Medicaid coverage compared with 27 percent of users with fewer visits.

- **Out-of-Pocket Spending by Visit Level and Income (Figure 1.12).** Among home health users with more than 100 visits, the group with the highest average out-of-pocket costs for all services, $7,127, are those with incomes from $15,001 to $25,000 per year. This group may face the highest out-of-pocket costs because they tend to have incomes above the level that would qualify them for Medicaid assistance. At the same time, they are less likely to have other insurance coverage. The next highest out-of-pocket costs, $3,952 are incurred by the over $25,000 income group. Individuals with incomes below $15,000 have the lowest out-of-pocket health care spending, $2,867 (reflecting Medicaid coverage in this group.)

Figure 1.1 Percent of Medicare Beneficiaries Who Use Home Health, Selected Years

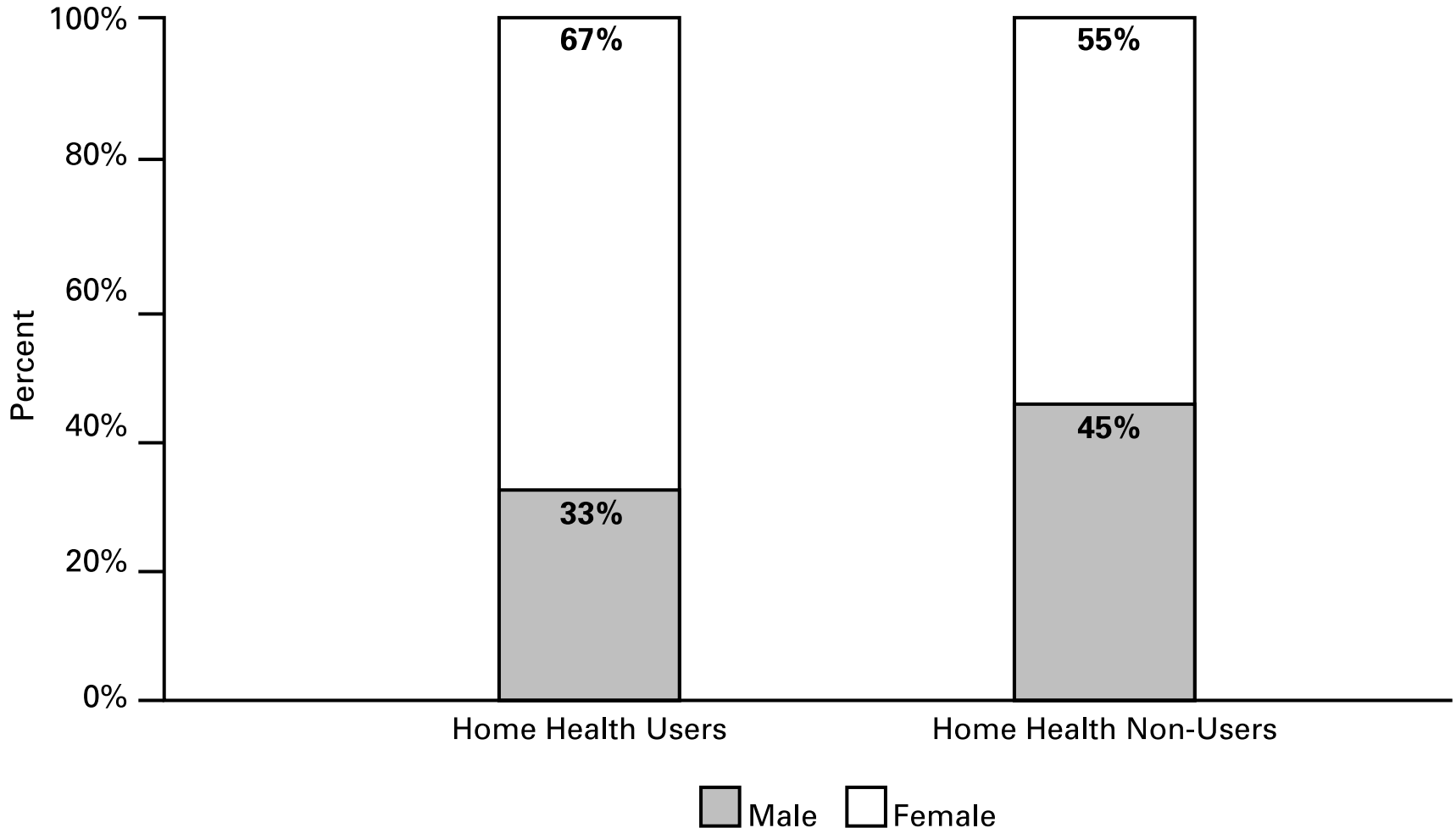
Since 1989, the percent of Medicare home health users has more than doubled.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 1.2 Gender of Home Health Users and Non-Users, 1995

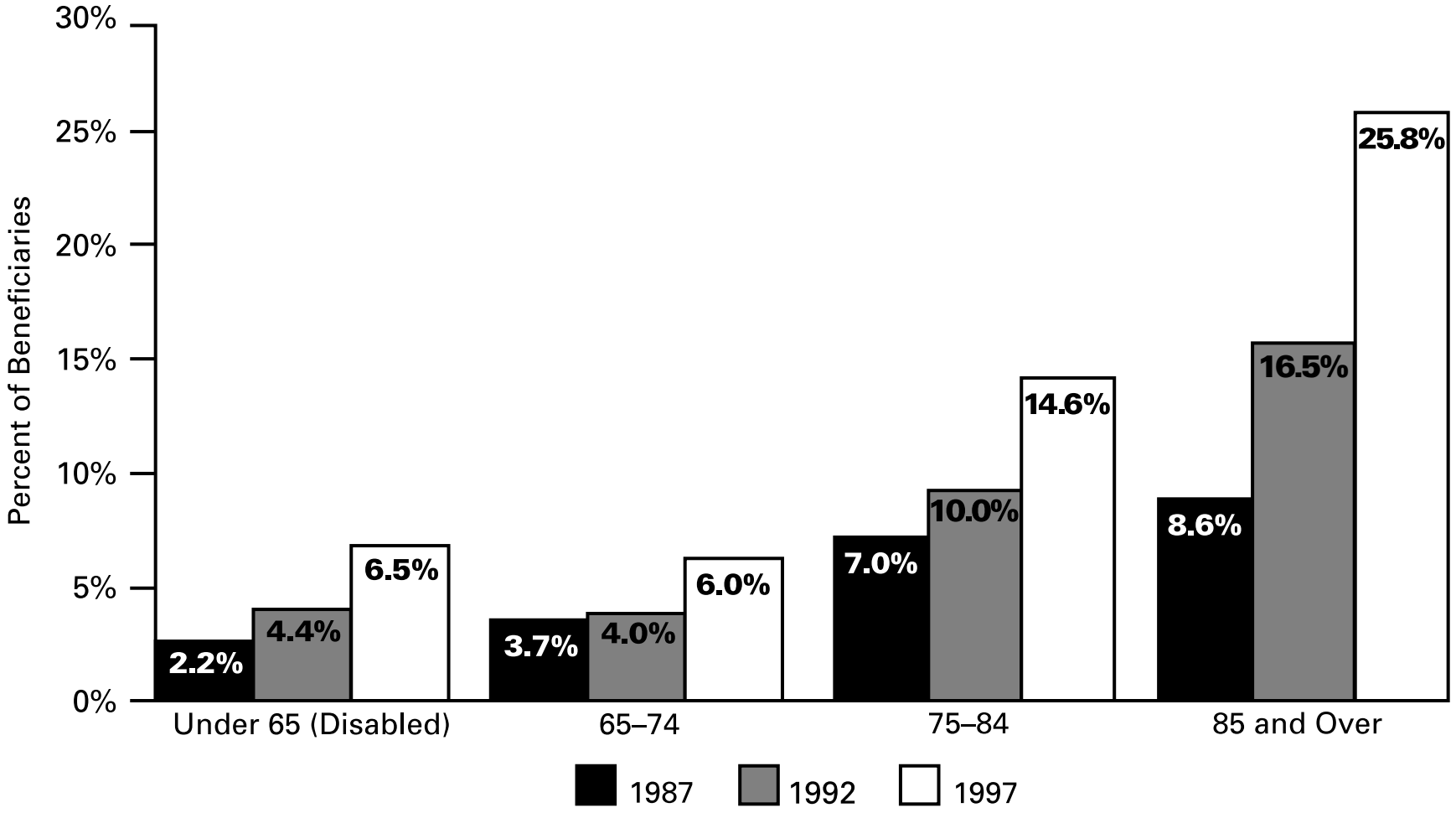
Home health users are more likely to be female than non-users.



Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.3 Percent of Medicare Beneficiaries in Each Age Group Who Use Home Health, 1987, 1992 and 1997

Home health use has increased, especially among the oldest and youngest (disabled) beneficiaries.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 1.4 Common Diagnoses of Home Health Users, 1997

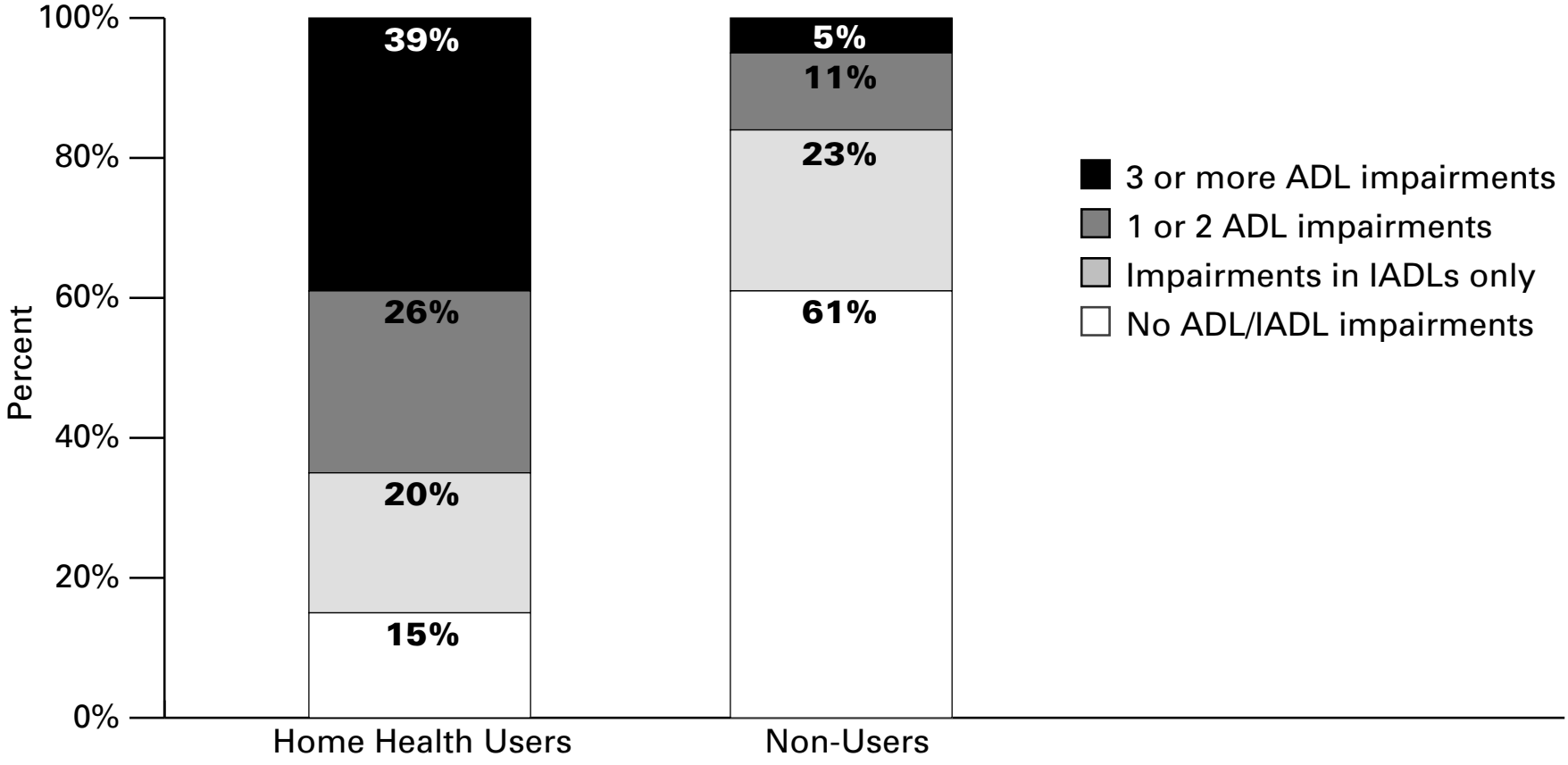
Diagnosis	Percent of Total Home Health Users with Diagnosis	Average Medicare Home Health Payment, 1997
Diabetes Mellitus	9.1%	$6,995
Essential Hypertension	6.9%	$3,447
Heart Failure	6.4%	$3,364
Osteoarthrosis and Allied Disorders	5.8%	$2,115
Cerebrovascular Disease	5.0%	$3,779
Chronic Skin Ulcer	4.2%	$6,171
Chronic Airway Obstruction	4.1%	$3,131
Other Forms of Chronic Ischemic Heart Disease	3.5%	$2,037
Cardiac Disrhythmias	3.2%	$2,611
General Symptoms	2.8%	$2,762

Note: In 1997, the total number of home health users was 3.6 million, and the average home health payment for all users was $4,704.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 1.5 Activities of Daily Living (ADL) Impairments of Home Health Users and Non-Users

Home health users have higher impairment rates compared to non-users.

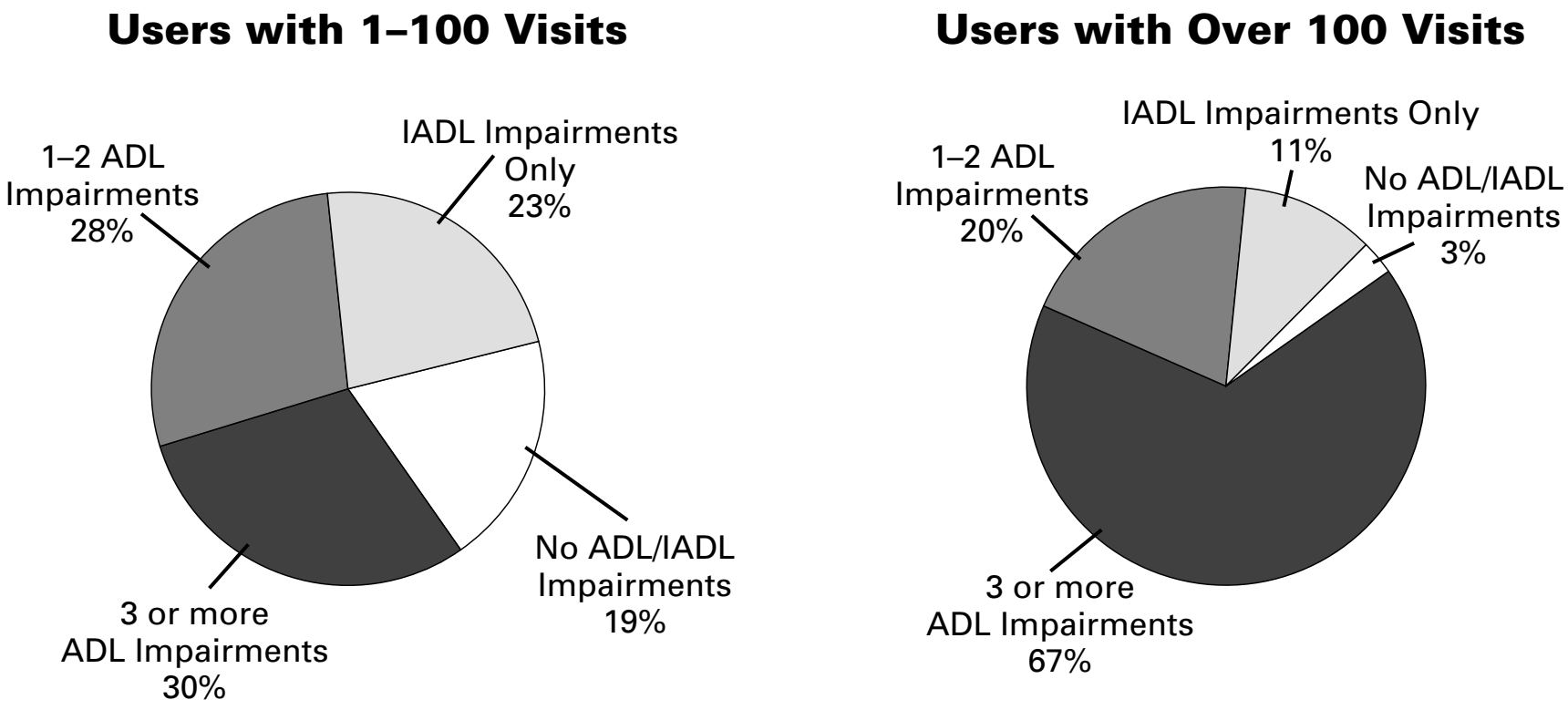


Note: ADL = Activities of Daily Living (e.g., bathing, eating); IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.6 Distribution of Home Health Users by Activities of Daily Living (ADL) Impairments and by Level of Visits, 1995

Home health users with over 100 visits have more functional limitations.

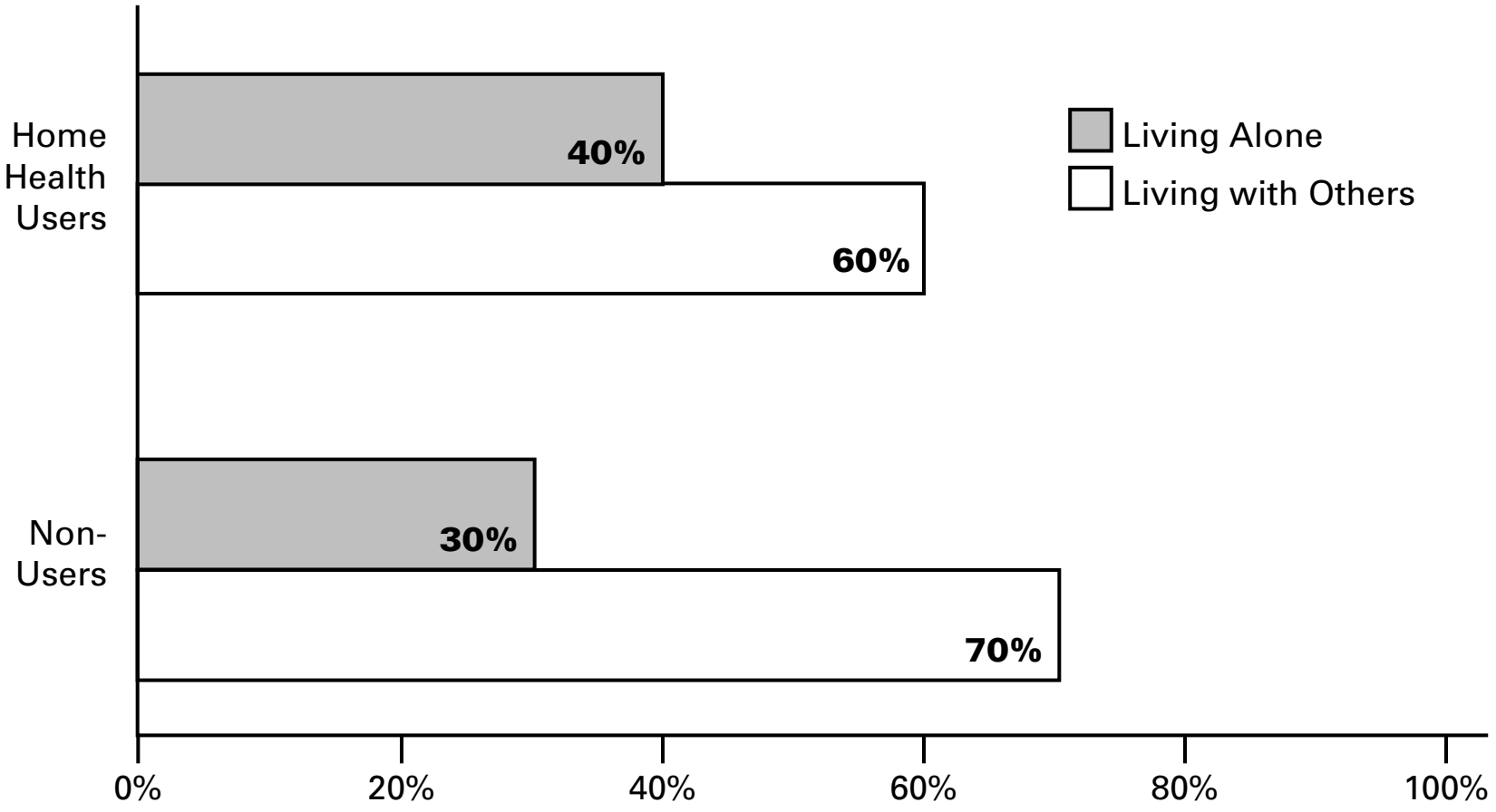


Note: ADL = Activities of Daily Living (e.g., bathing, eating). IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning). Percentages may not sum to 100 due to rounding.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.7 Living Arrangements of Home Health Users and Non-Users, 1995

Beneficiaries who use home health are more likely to live alone.

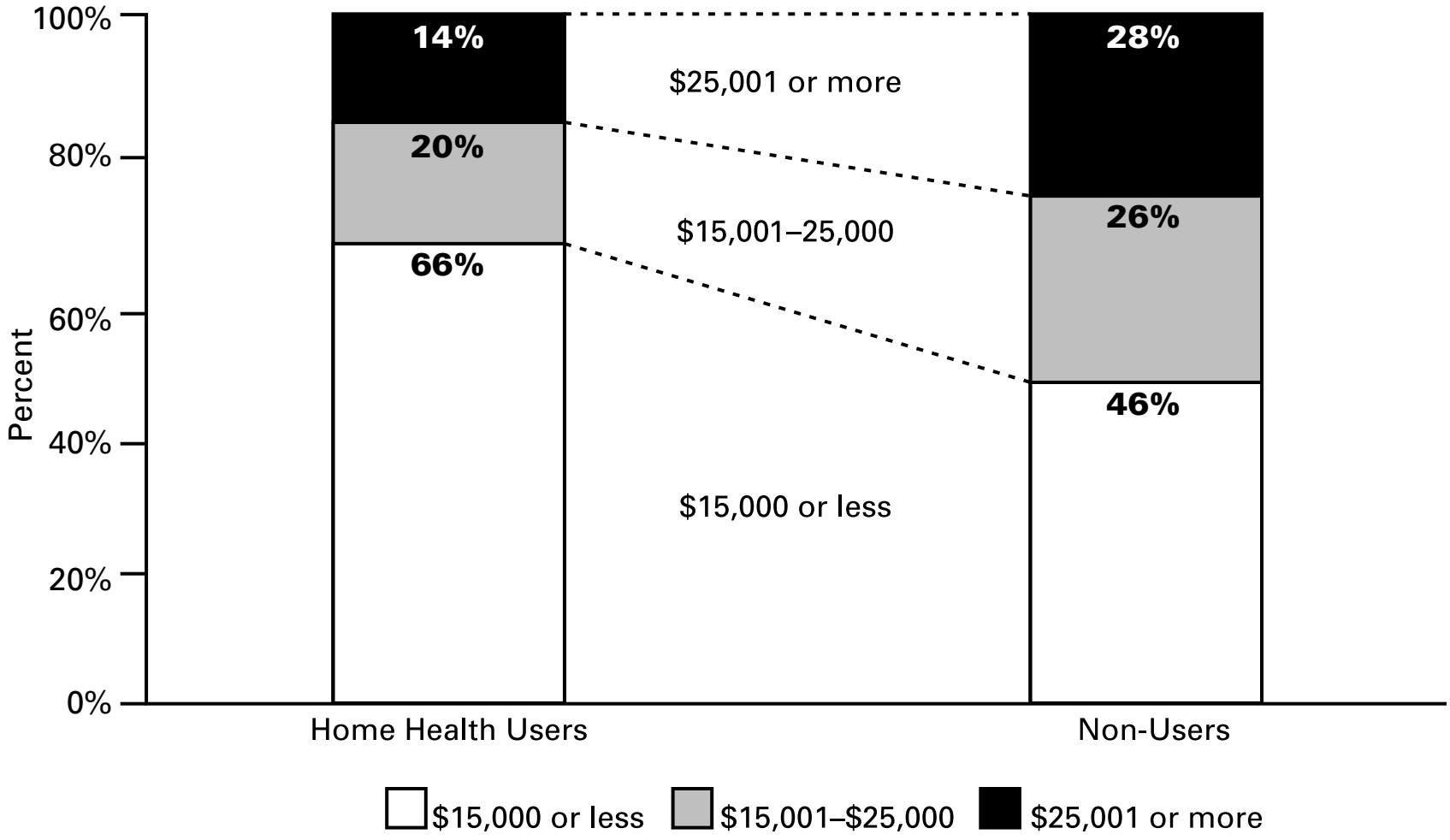


Note: "Others" include a spouse or children.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.8 Home Health Users and Non-Users by Income, 1995

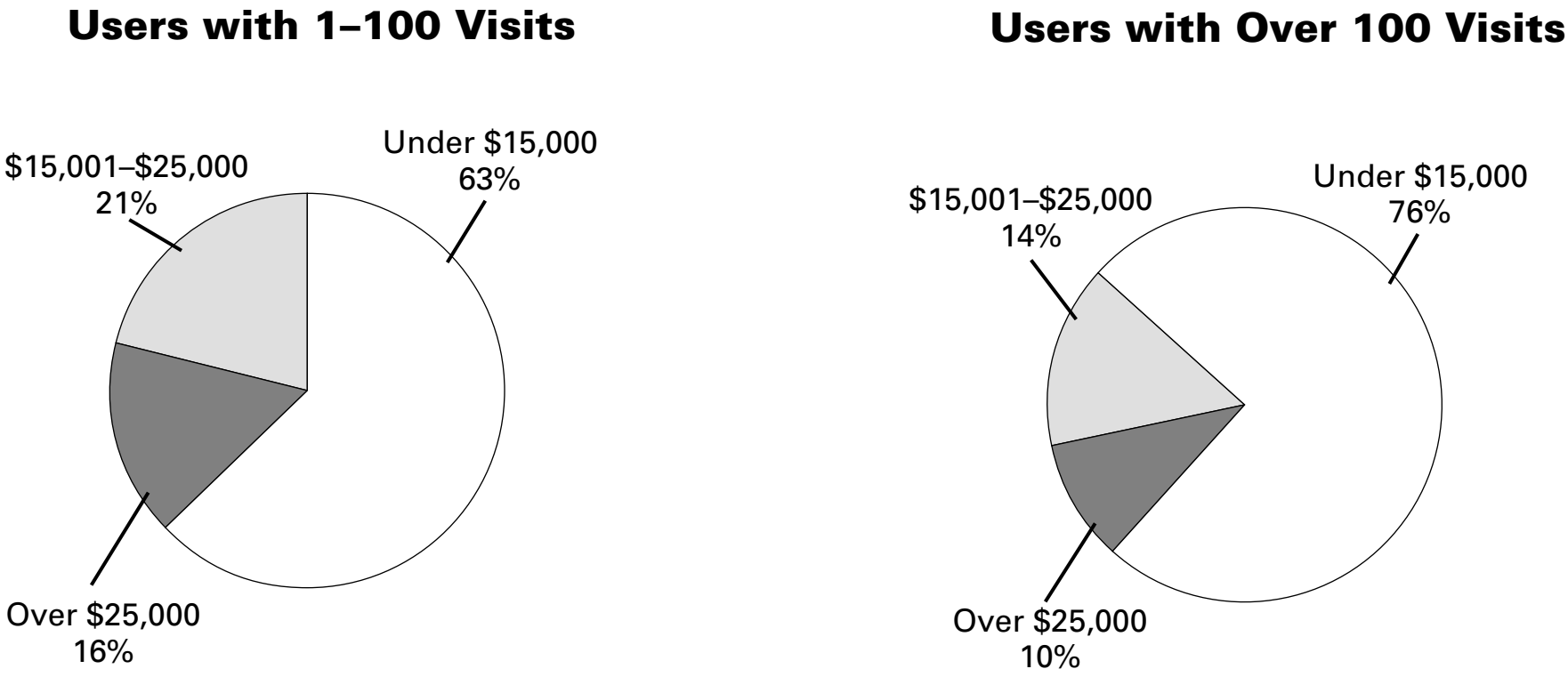
Two-thirds of home health users have incomes of $15,000 or less.



Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.9 Distribution of Home Health Users by Level of Visits and Income, 1995

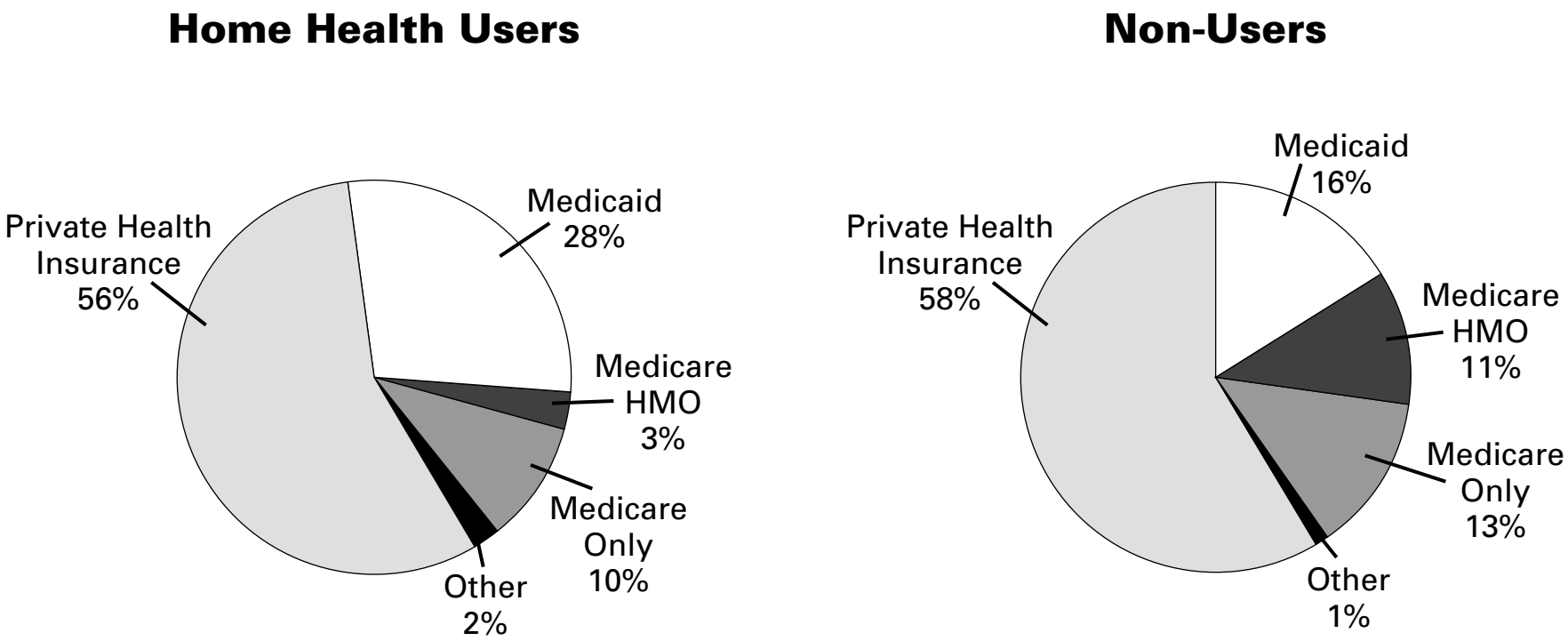
Home health users who receive over 100 visits tend to have lower incomes than those who receive fewer visits.



Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.10 Health Insurance Coverage for Home Health Users and Non-Users, 1995

A greater percentage of home health users have some Medicaid coverage than non-users.

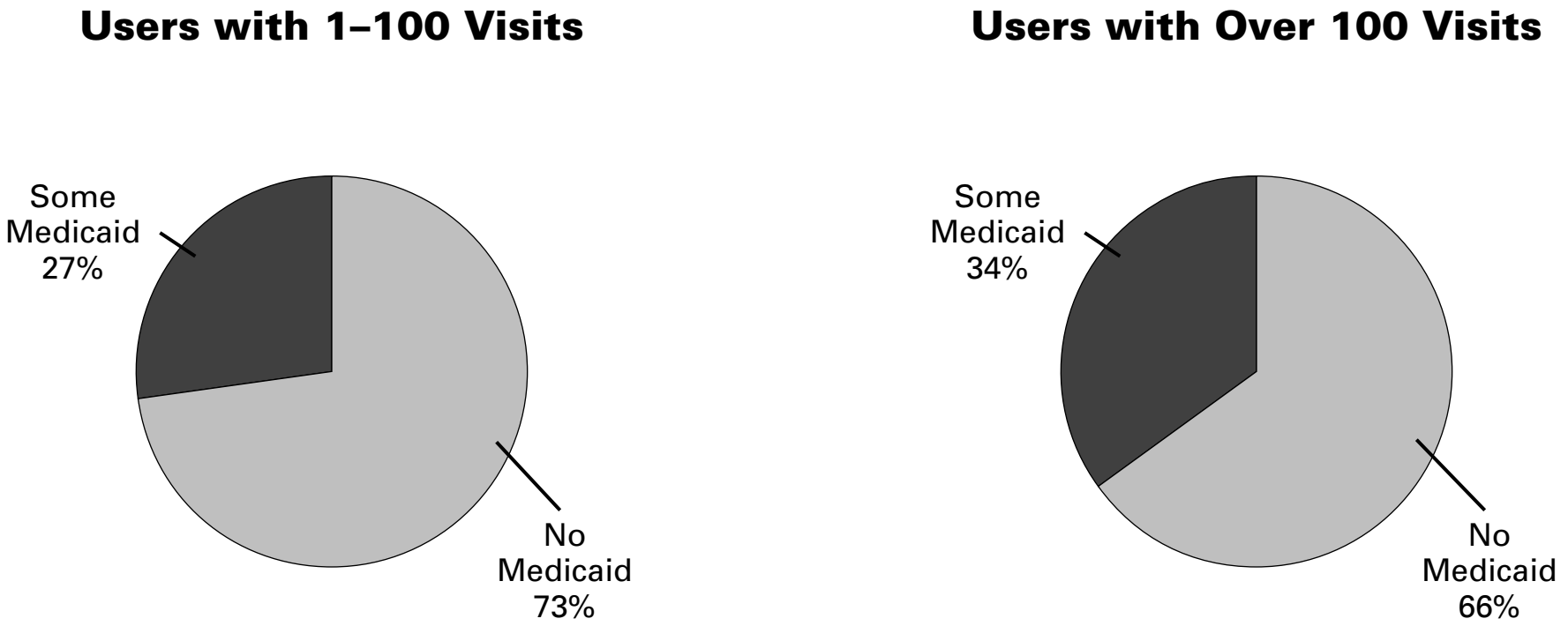


Note: Percentages do not sum to 100 due to rounding. The categories of insurance were derived from a hierarchical classification: Medicare HMO, Medicaid, Private Health Insurance, Other, Medicare only. In the course of a year, an individual may have had more than one category of insurance coverage.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.11 Medicaid Status of Medicare Home Health Users by Level of Visits, 1995

Home health users with over 100 visits are more likely to receive some Medicaid assistance.

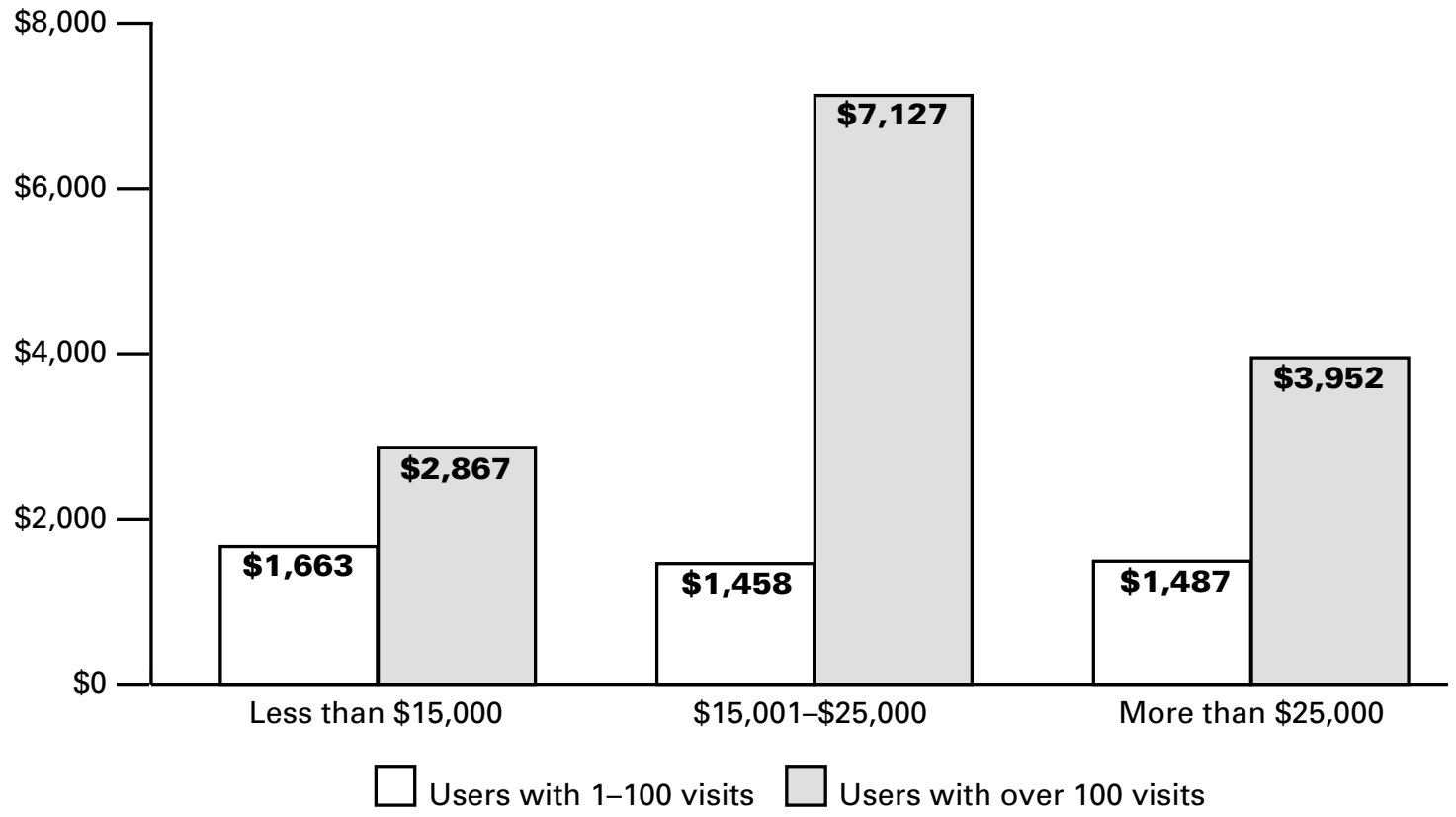


Note: "Some Medicaid" means the beneficiary either qualifies for full Medicaid benefits or receives Medicaid assistance in paying Medicare premium and cost-sharing requirements as a Qualified Medicare Beneficiary (QMB), or premium assistance as a Specified Low-Income Medicare beneficiary (SLMB).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 1.12 Out-of-Pocket Total Health Care Costs for Home Health Users, by Visit Level and Income, 1995

Because they are less likely to qualify for Medicaid but cannot afford supplemental coverage, individuals with over 100 visits and incomes from $15,001-$25,000 have the highest total out-of-pocket health care costs.



Note: Total out-of-pocket costs include coinsurance, copayments and deductibles. Medicare Part B premiums and private premiums are not included.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Home Health Utilization

SECTION 2

2. Home Health Utilization

Medicare home health use grew rapidly throughout much of the 1990s. The proportion of beneficiaries using home health increased from 5.8 percent in 1990 to 10.8 percent in 1997. During the same period, the average number of visits per home health patient doubled. The proportion of total home health users receiving 200 or more visits grew from 2.3 percent in 1990 to 9.7 percent in 1997. While home health use has grown rapidly across the U.S., utilization patterns differ considerably at the state level. (See Section 5, Medicare Home Health Data by State.)

One of the most significant factors contributing to the growth in home health use is the 1989 *Duggan v. Bowen* court case. Under the settlement the Health Care Financing Administration (HCFA) expanded the coverage criteria for the home health benefit. (See Section 6, A Medicare Home Health Primer.) As a result, the average number of visits per user and the number of individuals using the benefit increased rapidly.

In addition to the need for home health among individuals who require skilled medical care, there also has been a demand for custodial care[1] that by law is not covered under Medicare. Some of the increase in home health utilization may reflect an attempt to meet the need for this type of care. Data show that the increase in home health utilization stems in large part from the rising number of home health aide visits for personal care.

To a lesser extent, other factors have played a role in home health utilization growth — the understandable preference to receive care at home over an institutional setting and medical advances. Certain medical treatments, such as infusion therapy, that were once only possible in a hospital, now can be provided at home. In addition, the home health benefit may have been susceptible to waste, fraud and abuse. The U.S. General Accounting Office (GAO) noted "abusive billings for excessive care and visits for noncovered services," as another factor contributing to the growth in home health use.[2]

The rapid growth in home health utilization, however, is probably a phenomenon of the past. Although 1998 data are unavailable, the rate of growth in utilization is slowing. Between 1993 and 1995, there was a 26 percent increase in the number of home health visits. Between 1995 and 1997, this number was 1 percent. Further, reports from home health agencies indicate that the average number of visits per patient is declining.

Increased efforts to reduce fraud and abuse such as Operation Restore Trust launched in 1995 may have slowed utilization growth rates initially. Legislative changes in the Balanced Budget Act of 1997 are likely responsible for the reports of more recent declines in utilization. Although home health utilization appears to be decreasing, the General Accounting Office recently found that beneficiaries continue to have access to home health services.[3]

- **Visits (Figure 2.1).** In 1987, the annual average number of home health visits per user was 23. By 1991, this number nearly doubled to 45. Home health use continued to grow rapidly for several years, up to 74 in 1996 (not shown on chart). By 1997 however, the average number of home health visits per user dropped slightly to 73.

[1] Custodial care is personal care, such as help with bathing or dressing, that is unrelated to the skilled treatment of an illness or injury. Beneficiaries who only need personal care, not skilled medical care, are not eligible for Medicare home health. The home health benefit covers personal care when it augments skilled care in the overall treatment of a beneficiary who needs skilled medical care.

[2] U.S. General Accounting Office. GAO/HEHS-98-29. *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies.* December 1997, p. 1.

[3] U.S. General Accounting Office. GAO/HEHS-99-120. *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired.* May 1999.

- **Distribution of Home Health Users by Visits (Figure 2.2).** The distribution of home health patients by the number of visits they receive has changed over time. Most notable is the increase in the number of users with 200 or more visits. In 1987, less than 1 percent of all home health users received 200 or more visits per year. By 1997, about 10 percent of users had 200 or more visits. Note that the 10 percent of home health patients with 200 or more visits account for almost 46 percent of Medicare home health expenditures. (See Figure 3.4 in the Home Health and Medicare Spending section.)

- **Visits by Age (Figure 2.3).** Between 1987 and 1997, the average number of home health visits increased substantially for all age groups. Beneficiaries aged 85 and over have experienced the most rapid growth, with the average number of visits increasing from 24 in 1987 to 83 in 1997.

- **Visits by Gender (Figure 2.4).** In 1987 men and women averaged the same number of home health visits, 23. Gradually, however, women began to receive a greater number of visits. By 1997 men had an average of 66 visits per year while the average for women was 76. This is partly due to women's longer life spans and the greater functional limitations associated with advanced age.

- **Visits by Race (Figure 2.5).** Average visits for white and non-white home health patients were similar in 1987. Since that time, the average number of visits per user grew more rapidly among non-whites than whites. In 1997, whites averaged 68 visits per year while non-whites averaged 98 visits. The higher prevalence of functional impairments in the non-white population may partly explain the more rapid growth in home health visits. A 1999 study by the Department of Health and Human Services found that the most rapid growth in Medicare home health visits between 1989 and 1994 occurred among beneficiaries with functional impairments.[4]

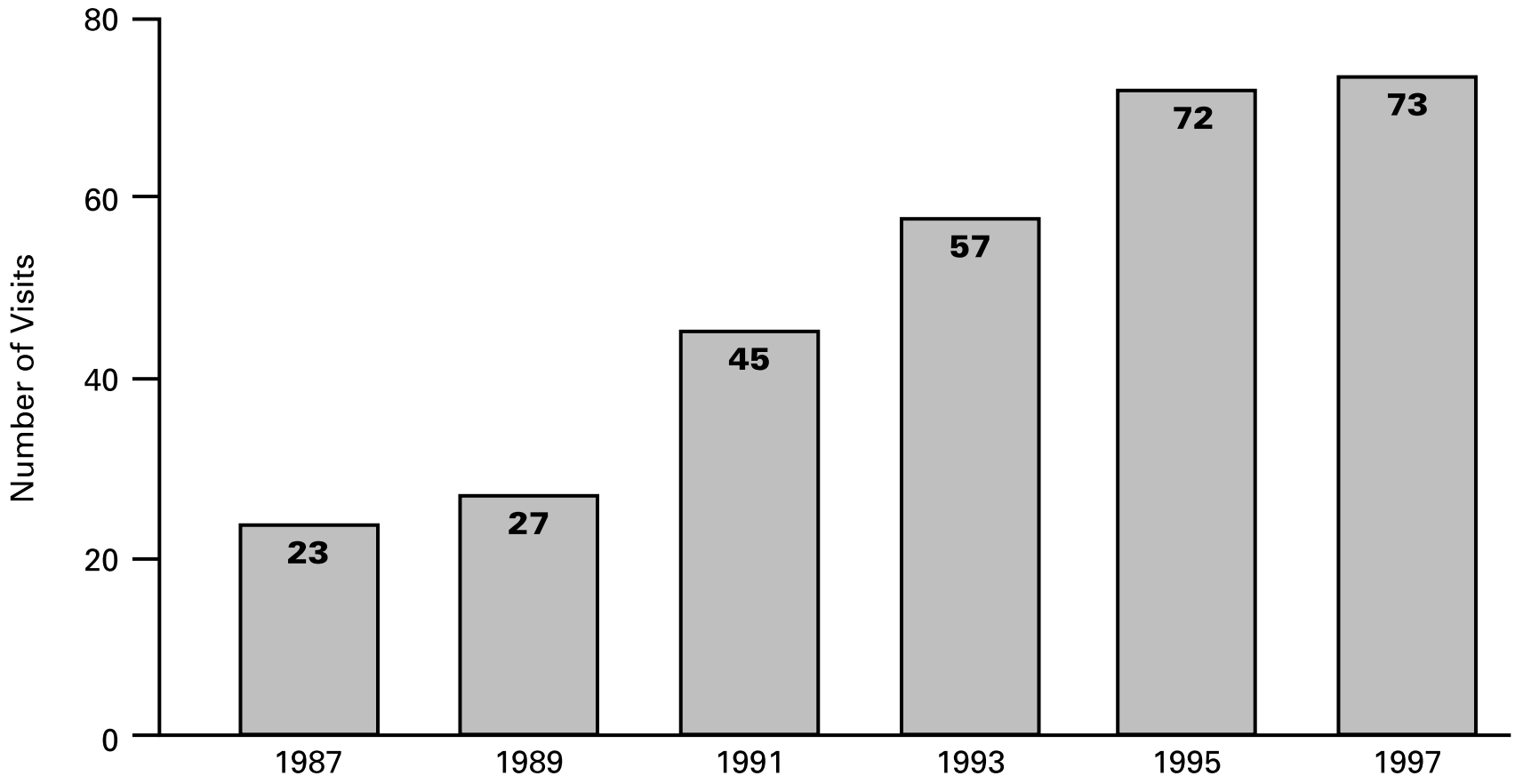
- **Visits by Geographic Location (Figure 2.6).** There is a difference in the average number of visits based on the home health patient's geographic location. Rural home health users averaged 81 visits while urban users averaged only 69 visits in 1997. There may be fewer community resources in rural areas, perhaps leading to greater use of Medicare home health.

- **Types of Visits (Figure 2.7).** Since 1987, the types of visits provided to home health users have changed. About 51 percent of total Medicare home health visits were for skilled nursing services in 1987. Home health aides accounted for 33 percent of total visits the same year. In 1997, skilled nursing visits fell to 41 percent, while aide visits jumped to 48 percent of all visits. Home health aides now account for the largest share of total visits.

[4] Unpublished Department of Health and Human Services (HHS) study. Jackson, Beth (MEDSTAT) and Doty, Pamela. "Medicare Home Health Services 1989-1994: Patterns of Benefit Use Among Chronically Disabled Elders." March, 1999.

Figure 2.1 Average Number of Visits per Home Health User, 1987–1997

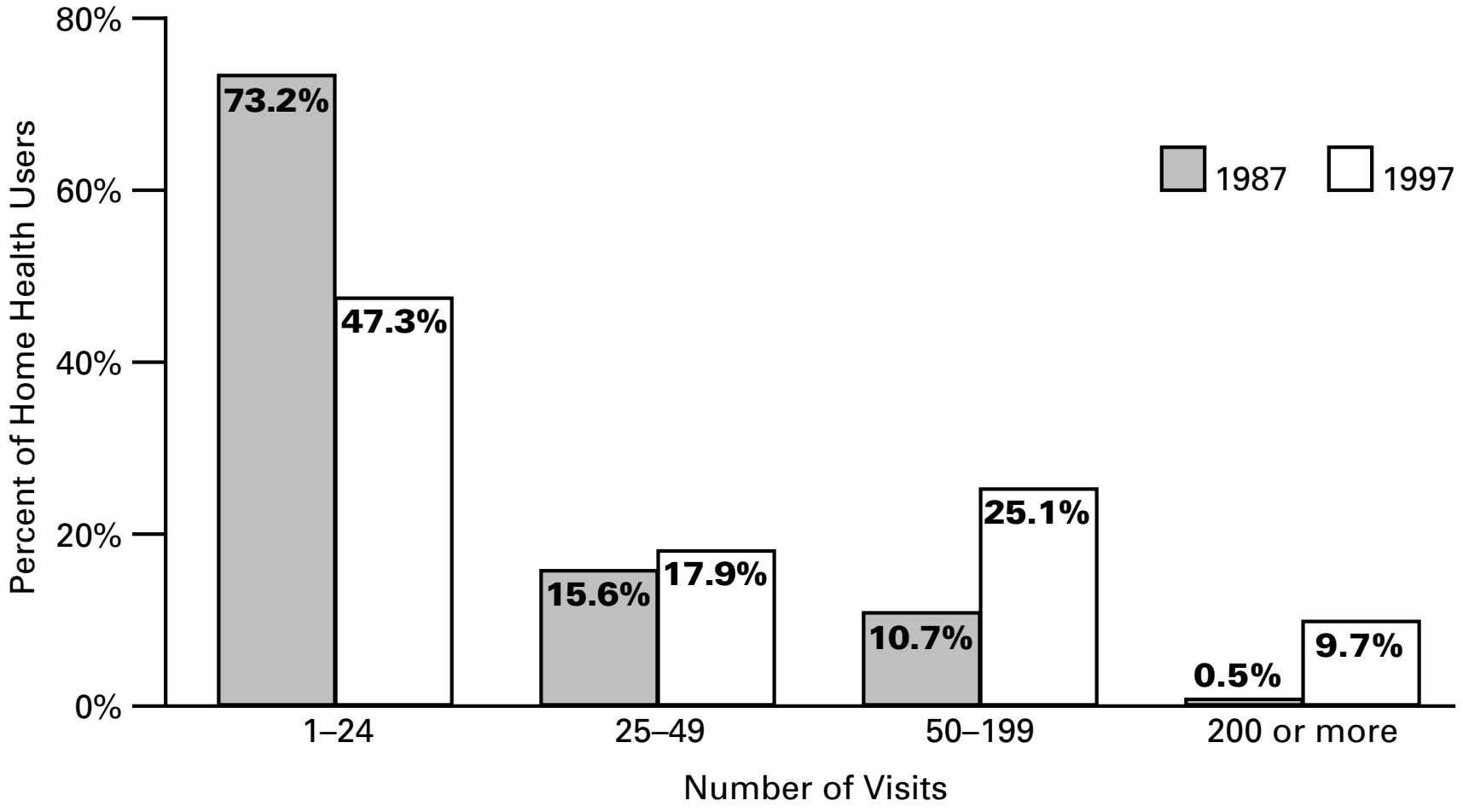
Since 1987, the average number of visits per home health user has more than tripled.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.2 Distribution of Home Health Users by Number of Visits, 1987 and 1997

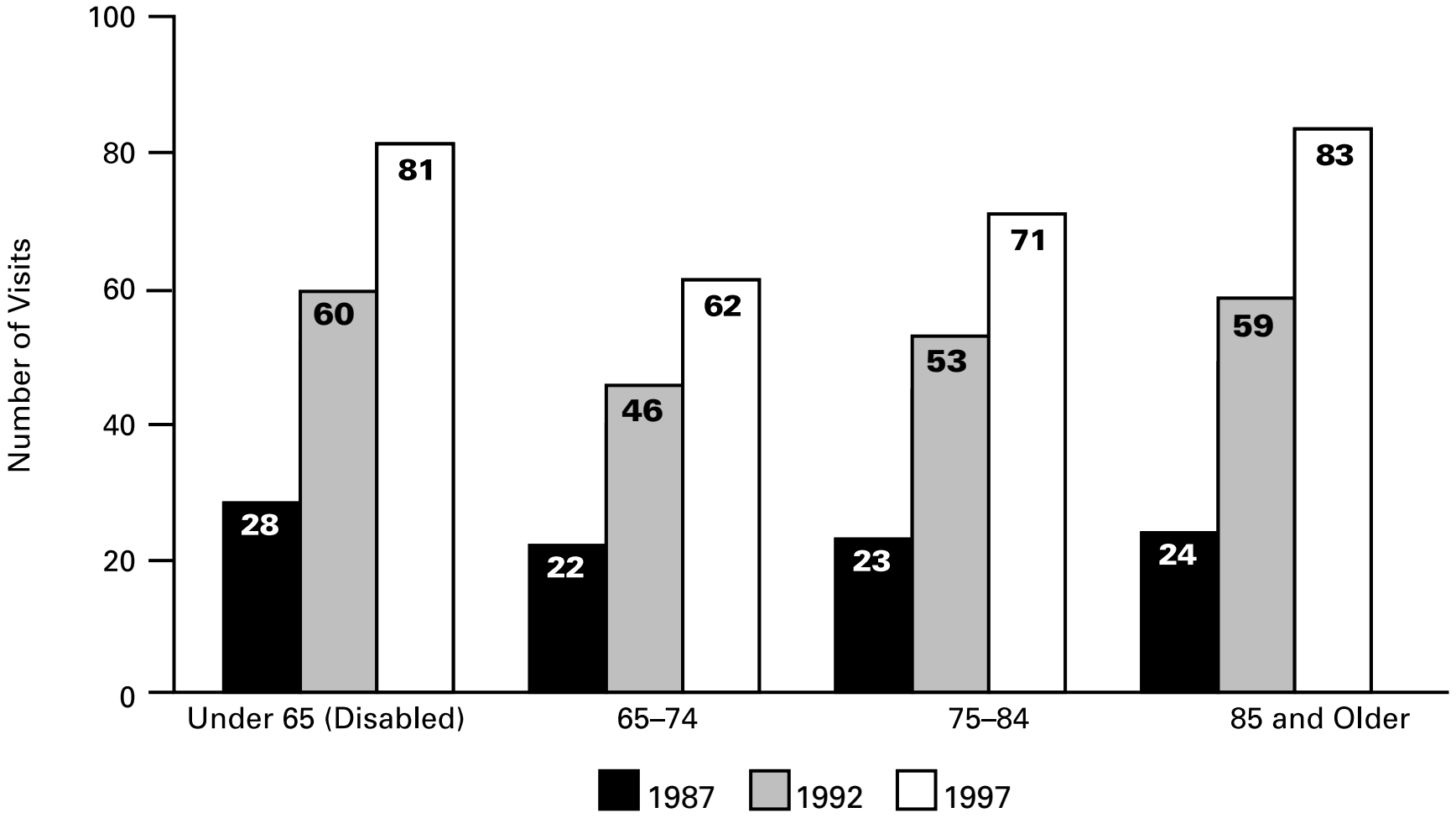
The proportion of users receiving 200 or more visits has grown substantially.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.3 Average Number of Home Health Visits per Beneficiary by Age, 1987, 1992 and 1997

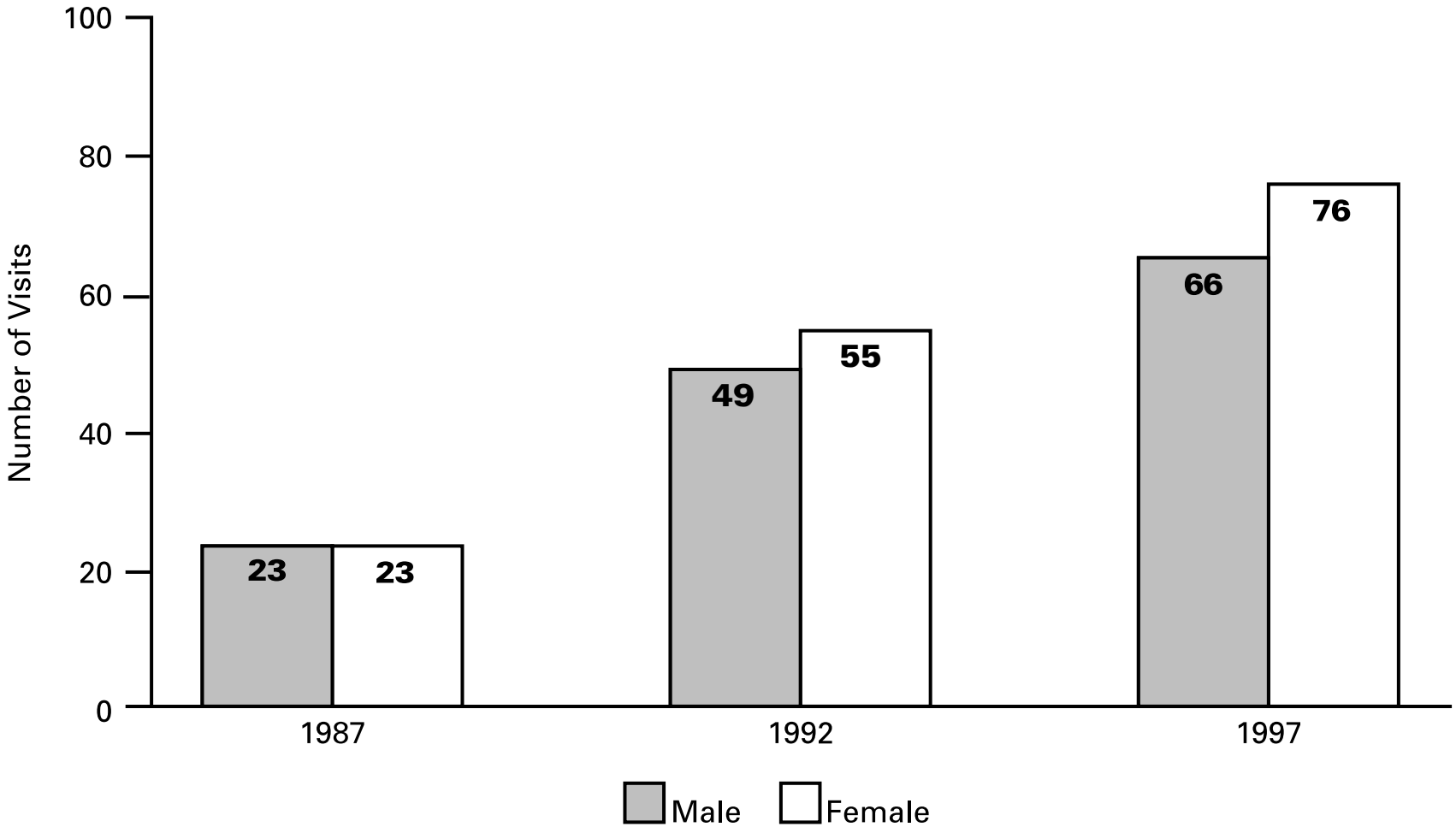
Home health use has roughly tripled for almost all ages, growing fastest for the oldest group of beneficiaries.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.4 Average Number of Visits for Male and Female Home Health Users, 1987, 1992 and 1997

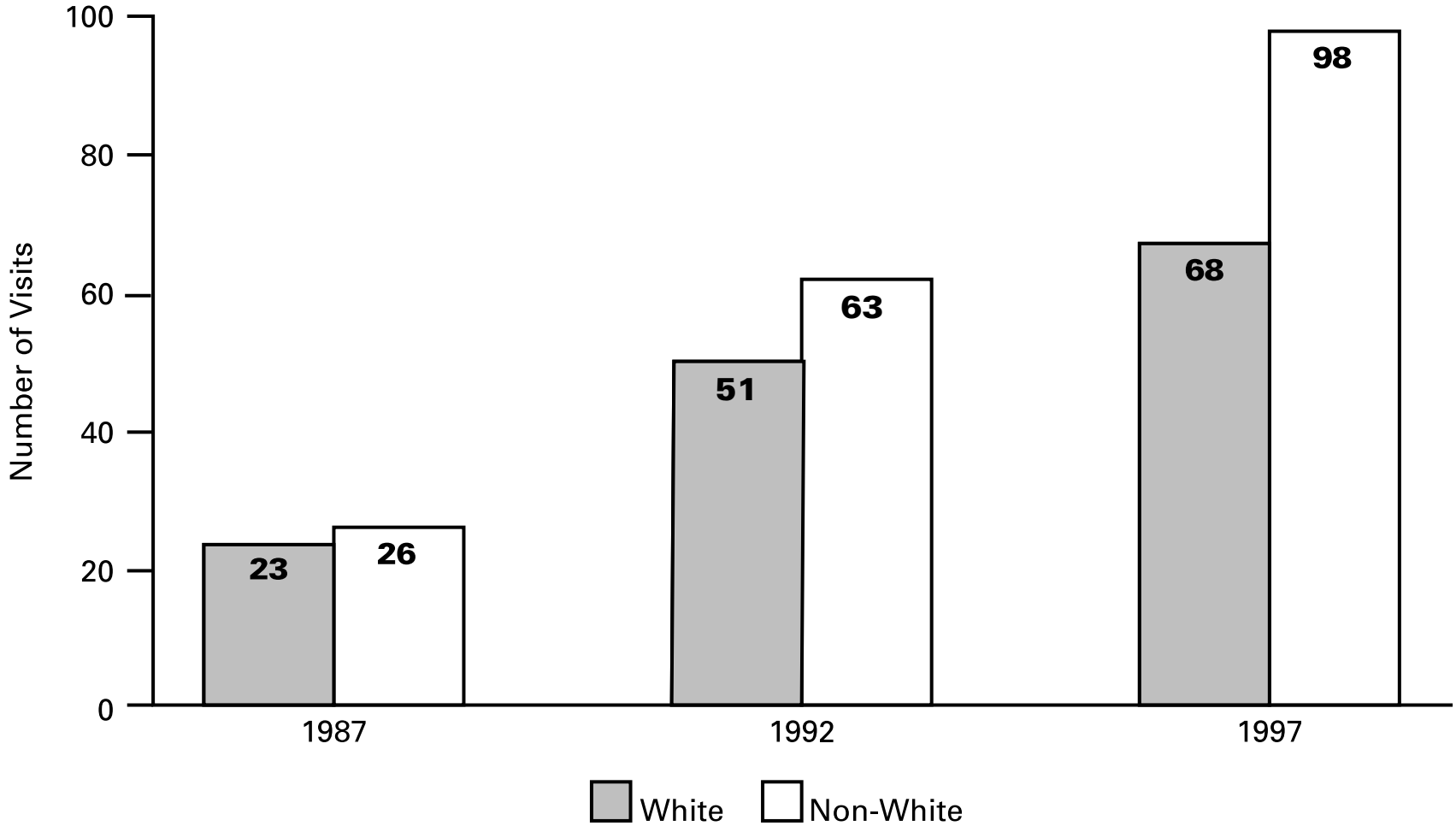
The average number of home health visits has grown for both men and women, but women now receive more visits.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.5 Average Number of Visits for White and Non-White Home Health Users, 1987, 1992 and 1997

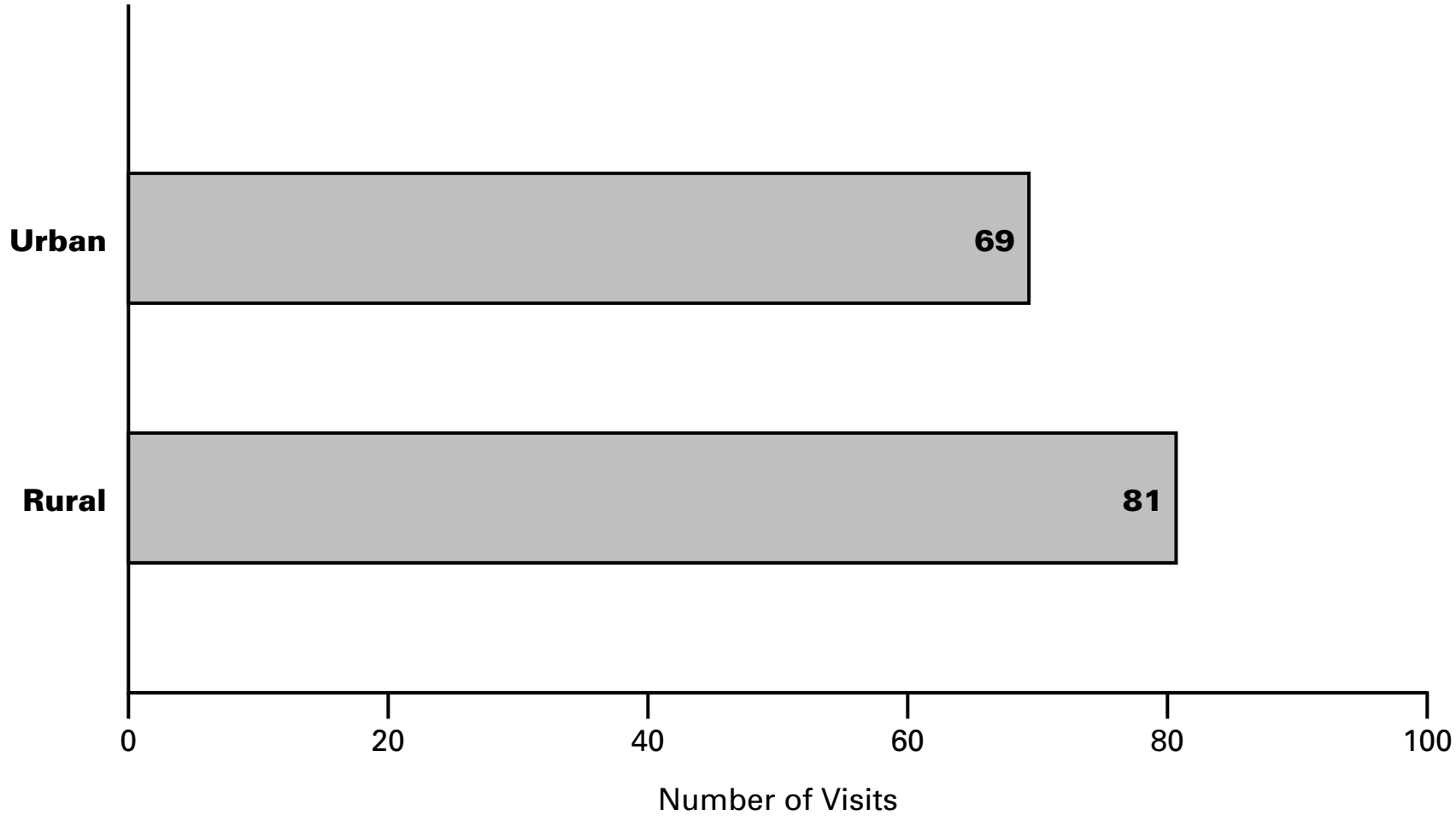
The average number of visits for non-whites has increased more rapidly than for whites.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.6 Average Number of Visits for Home Health Users in Rural and Urban Areas, 1997

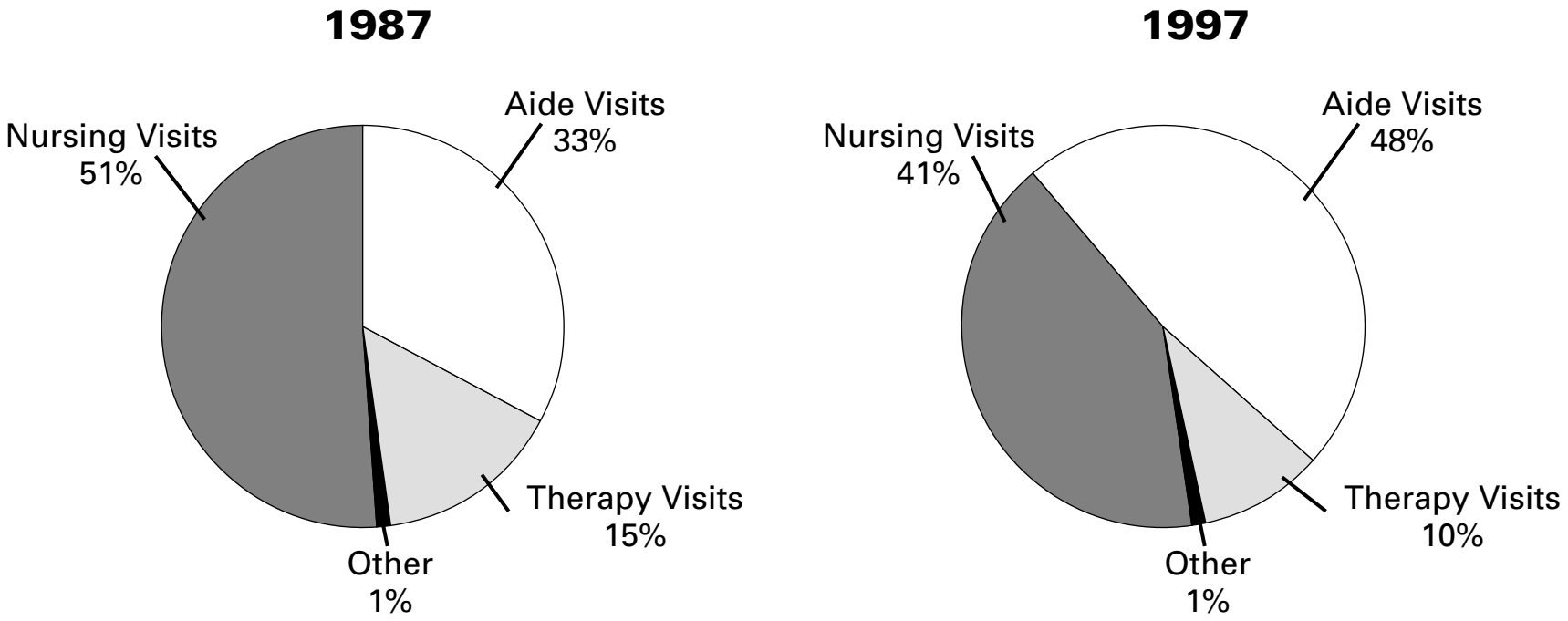
Home health patients in rural areas receive more visits than those in urban areas.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 2.7 Types of Medicare Home Health Visits as a Percent of Total Visits, 1987 and 1997

Aide visits are a growing proportion of home health services.



Note: Therapy visits include physical, speech and occupational therapy. The other category includes medical social services, medical supplies and durable medical equipment.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Home Health and Medicare Spending

SECTION 3

3. Home Health and Medicare Spending

Medicare spending on home health has grown substantially, reflecting the growth in utilization. From 1987 to 1997, Medicare home health expenditures increased at an annual average rate of 21 percent in real terms, reaching $16.7 billion in 1997.[1] As a share of total Medicare spending, home health rose from 2 percent in 1987 to 9 percent in 1997.

Many of the same reasons for the growth in the benefit's use apply to the rapid increases in spending. (See Section 2, Home Health Utilization.) A higher proportion of beneficiaries using home health and an increase in the number of home health visits per user primarily spurred spending growth. Payments per visit accounted for a relatively small amount of the growth. Medicare limits on costs per visit probably helped contain growth in per unit costs.

Growth in home health spending can also be attributed to a reduction in the number of claims the Health Care Financing Administration (HCFA) was able to review for medical necessity. At a time when resources for claims review dropped, the number of claims soared. Consequently, while HCFA reviewed over 50 percent of home health claims in fiscal year (FY) 1988, by FY 1997, HCFA only could review about 2 percent of these claims.

However, under initiatives to combat waste, fraud and abuse begun in 1996, HCFA increased medical review. These initiatives played a role in constraining home health spending growth. The 1999 Report of the Trustees of the Hospital Insurance Trust Fund states, "Growth slowed dramatically in 1996 and 1997 in part as a result of intensified efforts to identify fraudulent activities in this area."[2]

Other factors have a role in the deceleration in home health spending growth as well. The 1999 Trustees' Report also finds, "The growth in the benefit is further slowed by the enactment of the Balanced Budget Act."[3] The increased enrollment of beneficiaries in managed care also may be affecting the rate of change in fee-for-service home health expenditures.

- **Revenue Sources for Freestanding Home Health Agencies (Figure 3.1).** Providers that are not associated with a hospital or nursing home are known as freestanding home health agencies. In 1997, freestanding agencies represented 73 percent of all Medicare-certified home health providers.

  In real terms, freestanding home health agencies' total revenue from all sources equaled $9.6 billion in 1987 and climbed to $22.6 billion in 1992. By 1997, this number reached $32.3 billion. Total revenues for freestanding providers include Medicaid, Medicare, other private funds (primarily philanthropy), private health insurance, out-of-pocket spending and state and local assistance programs.

- **Share of Funding Sources for Freestanding Home Health Agencies (Figure 3.2).** As noted above, total revenues for freestanding home health providers increased from 1987 to 1997. While revenues from all sources grew, revenues from Medicare grew fastest. In 1987 Medicare accounted for 22 percent of total home health revenues for freestanding agencies. By 1997 this number reached 40 percent.

- **Total Real Medicare Home Health Spending (Figure 3.3).** In 1987, total Medicare spending on home health was $2.6 billion in real terms (1997 dollars). After peaking at $17.2 billion in 1996 (not on chart), spending totaled $16.7 billion in 1997 in real terms. Anti-fraud efforts aimed at the home health benefit and increased

[1] The portion of Medicare capitation payments to managed care plans that are used for home health services are not included in these figures. HCFA does not currently collect such data from managed care plans.

[2] 1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, p. 59.

[3] *Ibid*.

enrollment in managed care likely contributed to the decrease in Medicare home health spending from 1996 to 1997.

- **Distribution of Medicare Home Health Expenditures by Number of Visits (Figure 3.4).** Largely due to the substantial growth in number of visits per home health patient, nearly half of all Medicare home health spending is for individuals with 200 or more visits per year. In contrast, only 5 percent of total home health spending was for patients with 200 or more visits in 1987.

- **Real Home Health Payment per User (Figure 3.5).** In real terms, the average Medicare home health payment per home health user almost tripled from 1987 to 1997, growing an average of 11 percent per year. Note, however, that real home health payment per home health patient dipped slightly from $4,793 in 1996, to $4,704 in 1997.

- **Medicare Spending for Home Health Users and Non-Users (Figure 3.6).** On average, Medicare spending on home health users (excluding their home health costs) was five times greater than for beneficiaries who did not use home health in 1997. In real terms, the average Medicare payment for a beneficiary without home health use was relatively constant in 1987, 1992, and 1997.

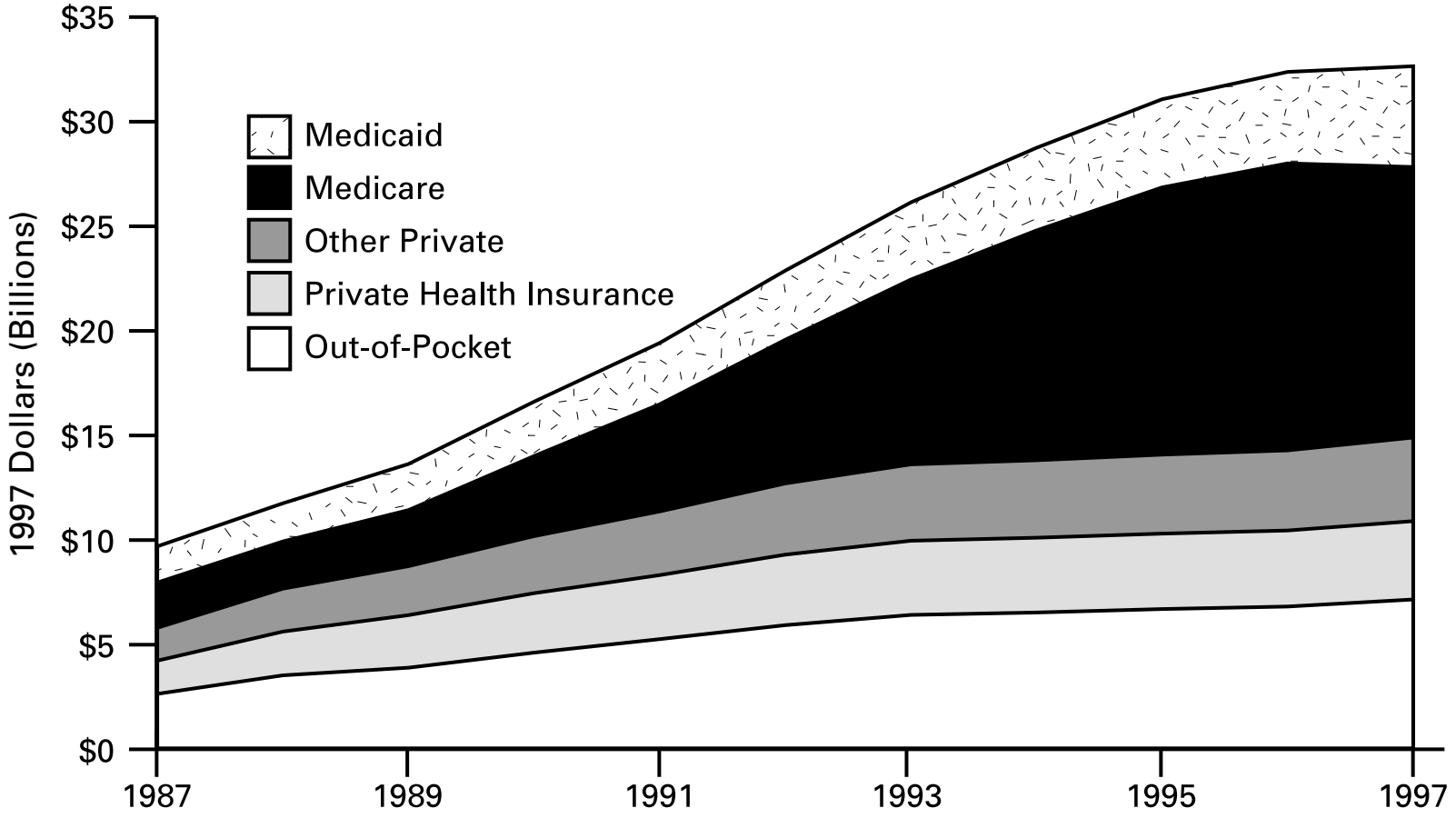
- **Average Home Health Payment by Functional Impairment (Figure 3.7).**[2] As expected, home health users with the greatest number of functional limitations are the most costly. In 1995, the average payment for home health users with 3 or more ADL impairments was more than four times the $1,830 average payment for users with no ADL or IADL limitations.

- **Components of Medicare Home Health Spending Growth (Figure 3.8).** Medicare home health spending growth has been driven largely by increases in home health utilization. A surge in the average number of visits per user is the largest factor, accounting for 47 percent of Medicare home health spending growth from 1990 to 1997. Substantial increases in the proportion of beneficiaries using home health also comprised a large share of spending growth, 38 percent. The average Medicare payment per home health visit accounted for a smaller portion of the growth in spending, about 14 percent. Finally, increases in Medicare fee-for-service enrollment only comprised 1 percent of Medicare home health spending growth.

[2] Note: ADL = Activities of Daily Living (e.g., bathing, eating).
IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning).

Figure 3.1 Revenue Sources for Freestanding Home Health Agencies, 1987–1997

In 1997, freestanding home health agency revenues topped $32 billion.

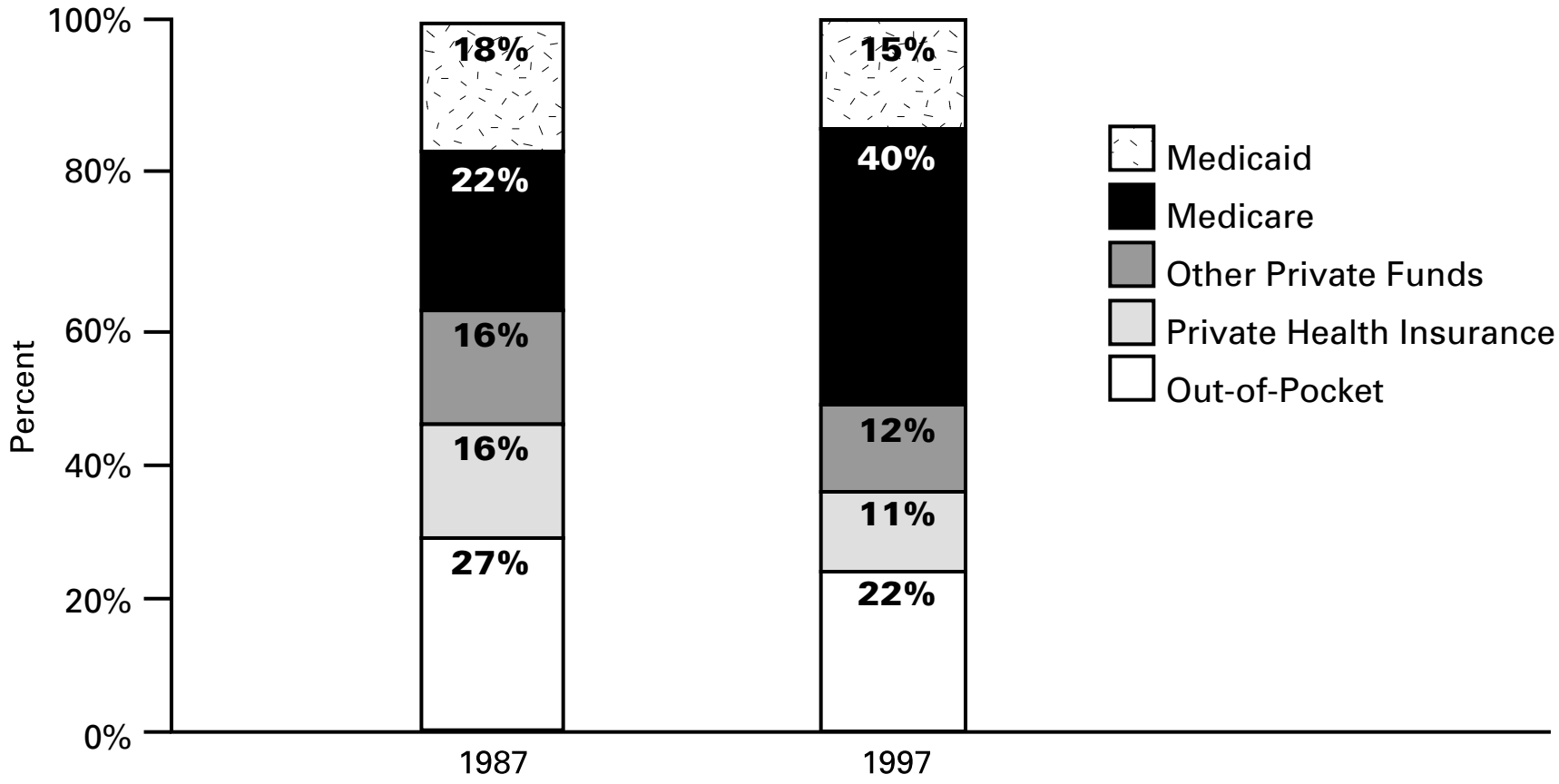


Note: The deflator is the home health input price index. "Other private funds" refers to revenues for which no direct patient care is furnished. The primary source of these revenues is philanthropy. Also, the data do not include state and locally funded "general assistance programs," which represent a small portion of freestanding agencies' revenues.

Source: HCFA Office of the Actuary, National Health Statistics Group.

Figure 3.2 Share of Funding Sources for Freestanding Home Health Agencies, 1987 and 1997

Medicare and Medicaid together now account for more than half of freestanding agencies' revenue.

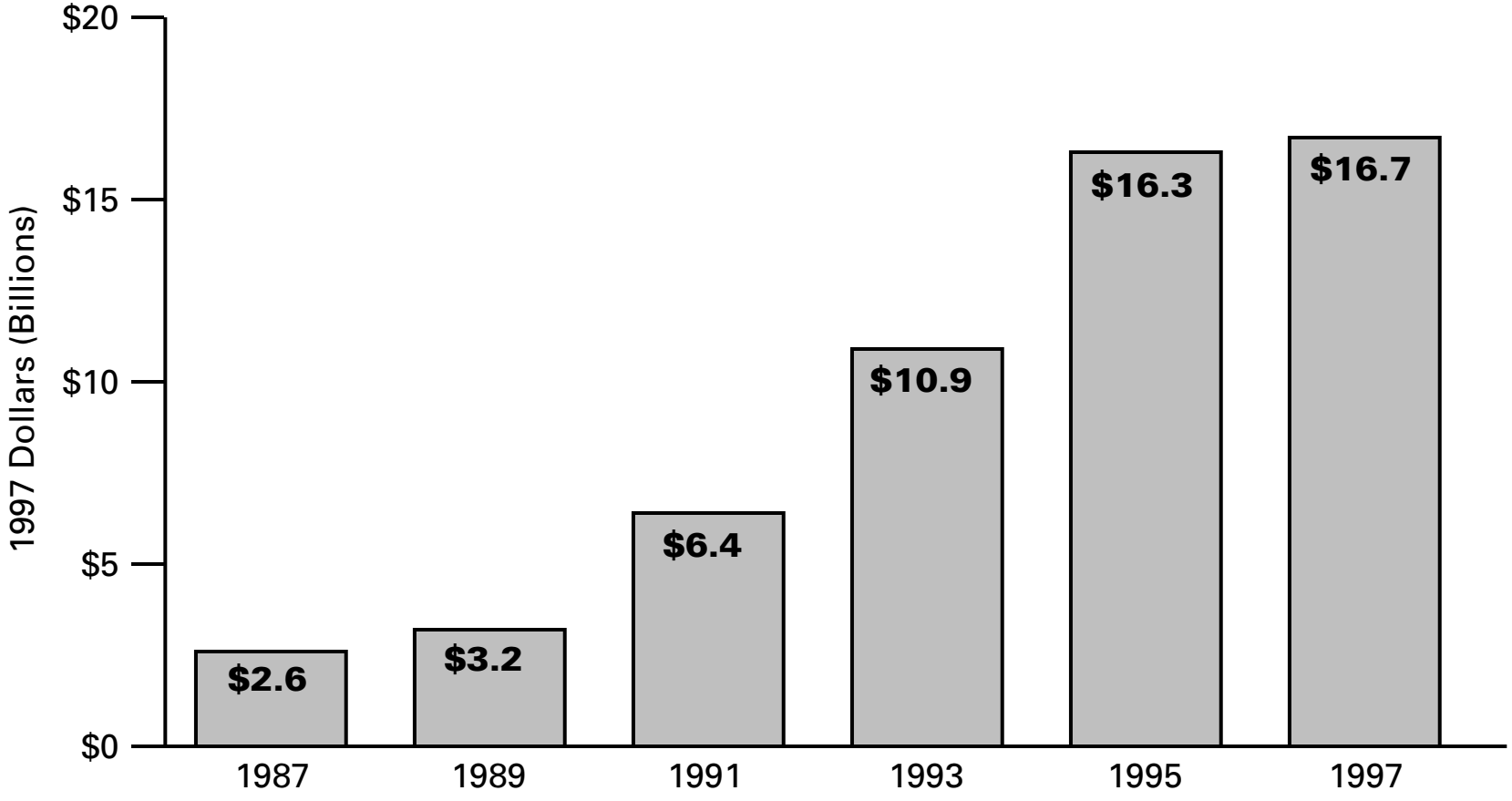


Note: "Other private funds" refers to revenues for which no direct patient care is furnished. The primary source of these revenues is philanthropy. Percentages may not sum to 100 due to rounding.

Source: HCFA Office of the Actuary, National Health Statistics Group.

Figure 3.3 Total Real Medicare Home Health Spending, 1987–1997

After increasing rapidly for several years, total real Medicare home health spending growth has slowed.

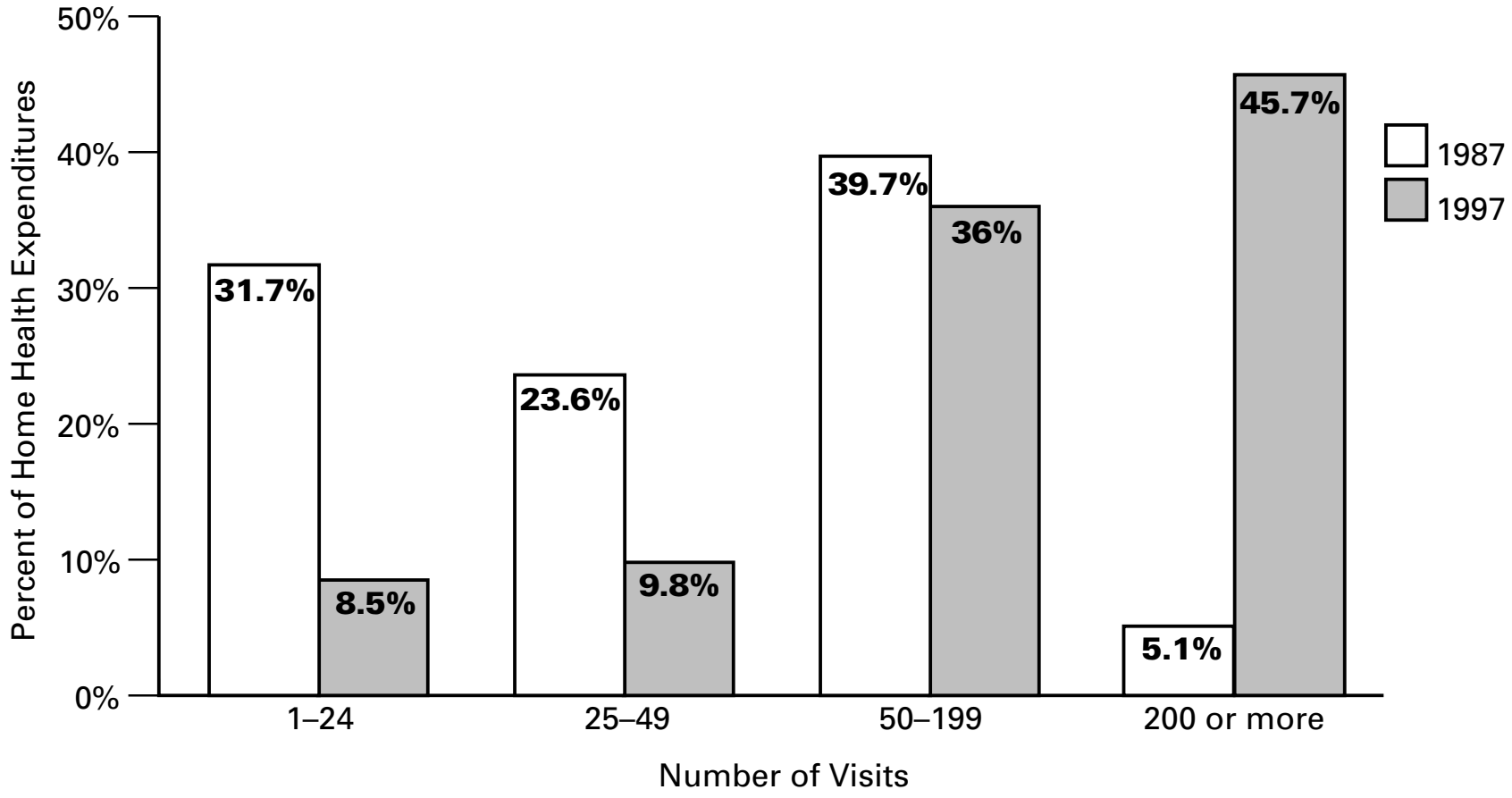


Note: The deflator is the home health input price index.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 3.4 Distribution of Medicare Home Health Expenditures by Number of Visits, 1987 and 1997

Users with 200 or more visits now account for nearly half of home health spending; in 1987 they accounted for only one-twentieth.

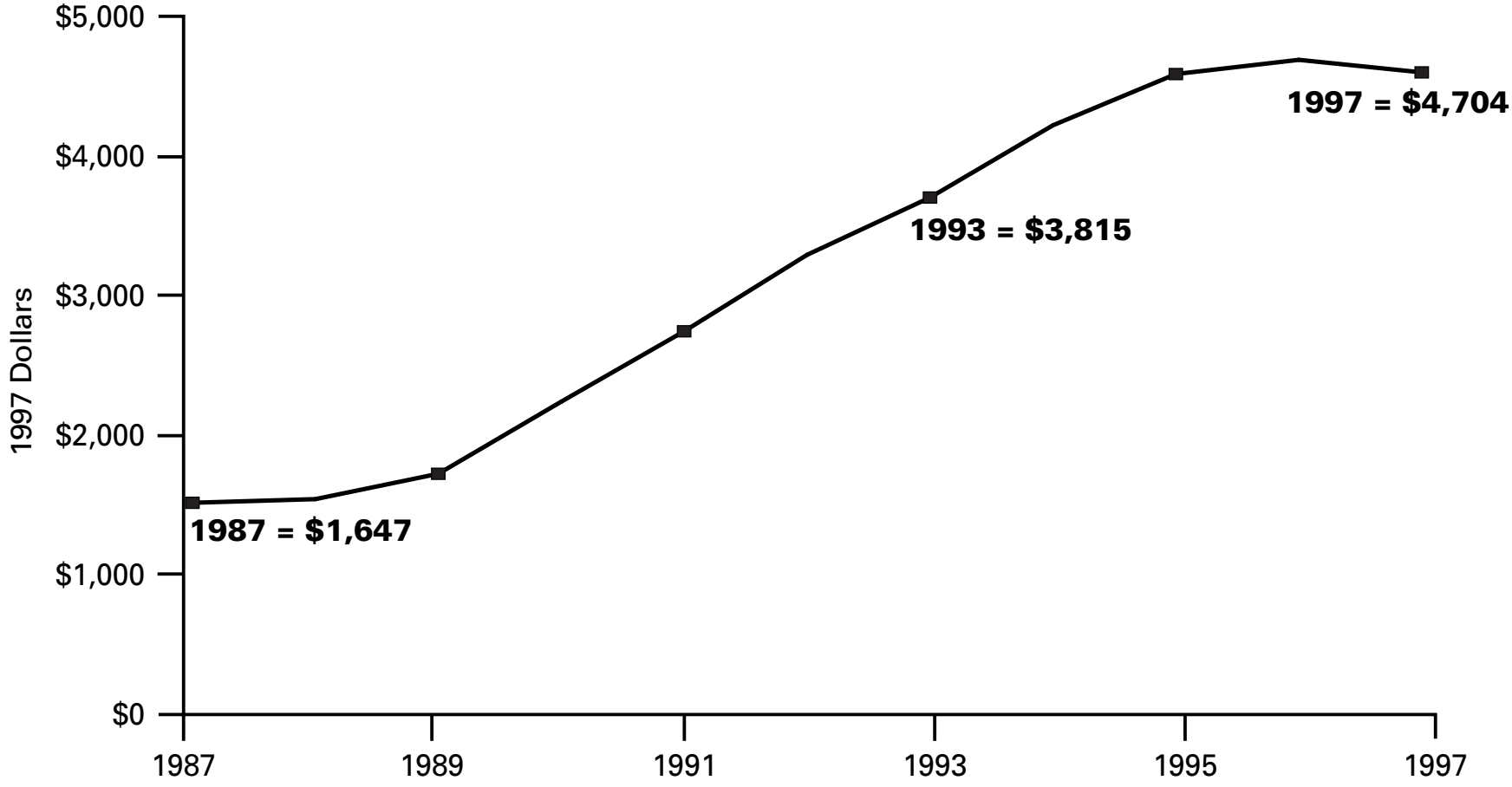


Note: Percentages may not sum to 100 due to rounding.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 3.5 Average Real Home Health Payment per Home Health User, 1987–1997

After steady growth during most of the 1990s, the average real payment per home health user dropped slightly in 1997.

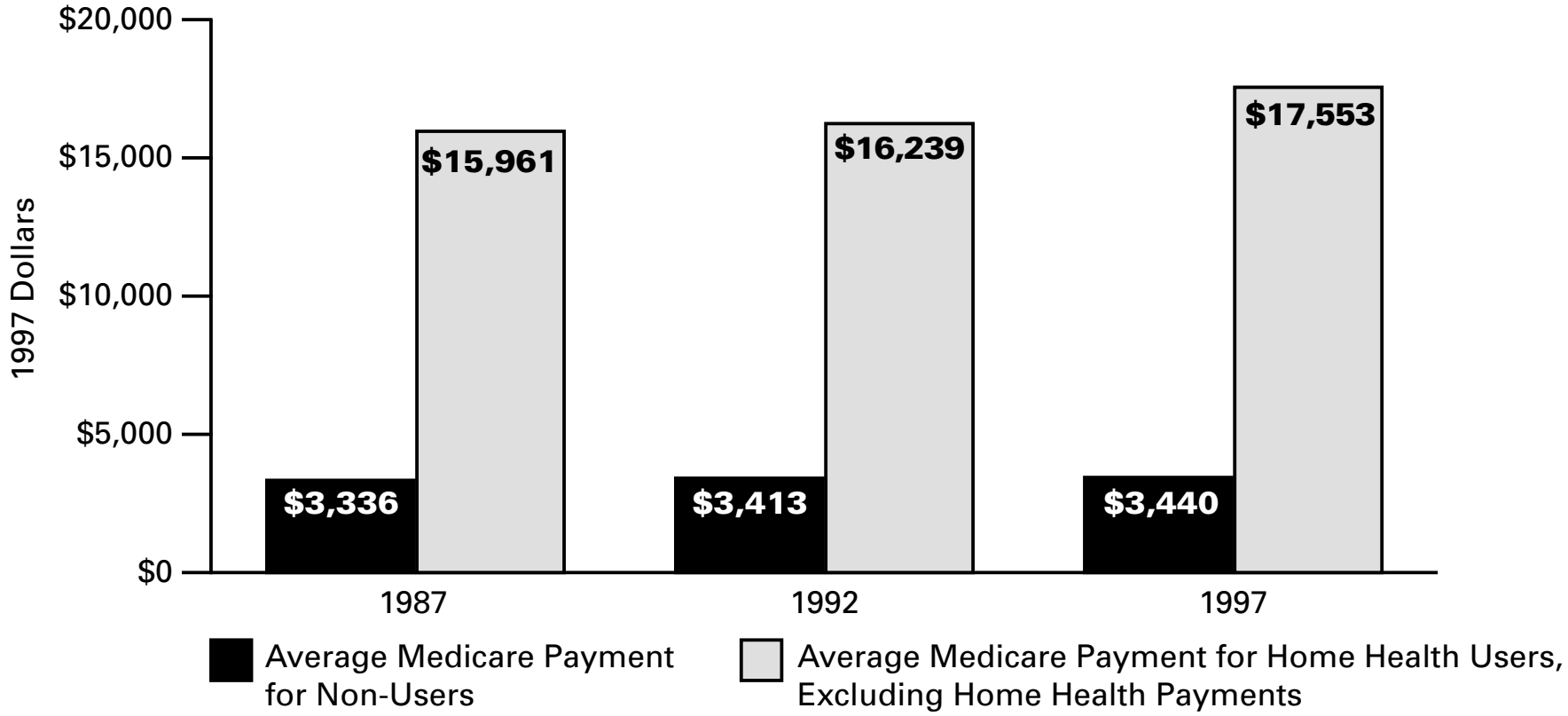


Note: The deflator is the home health input price index.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 3.6 Average Real Medicare Expenditures (Excluding Home Health) for Home Health Users and Non-Users, 1987, 1992, 1997

Average Medicare payments, excluding home health, are significantly higher for users than for non-users.

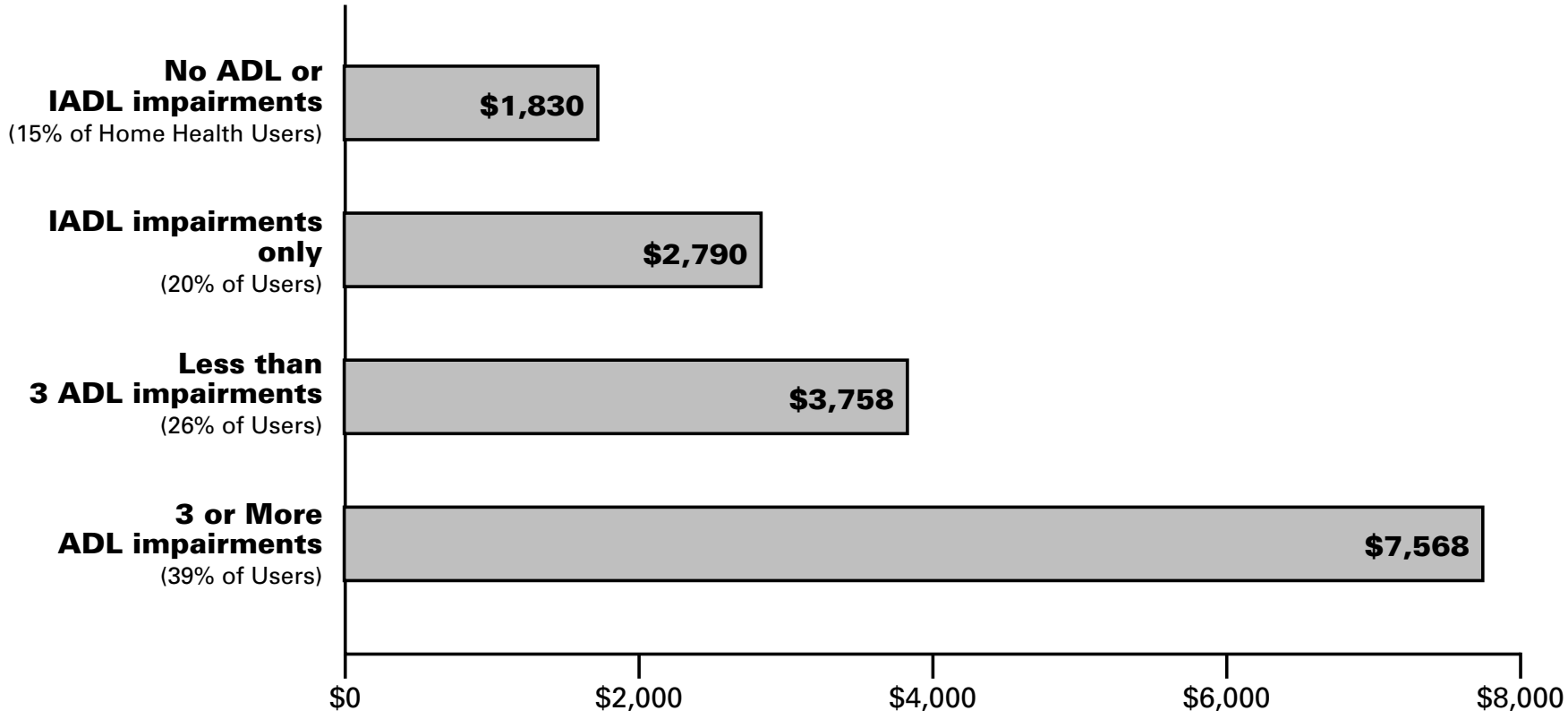


Note: The deflator is the GDP price index. Data are from the Medicare claims of a 5% sample of beneficiaries. See "Note on Data Sources" at the end of the chart book for a description of this and other data used.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 3.7 Average Home Health Payment for Home Health Users by Functional Impairment, 1995

Payments are highest for users with the greatest number of functional limitations.

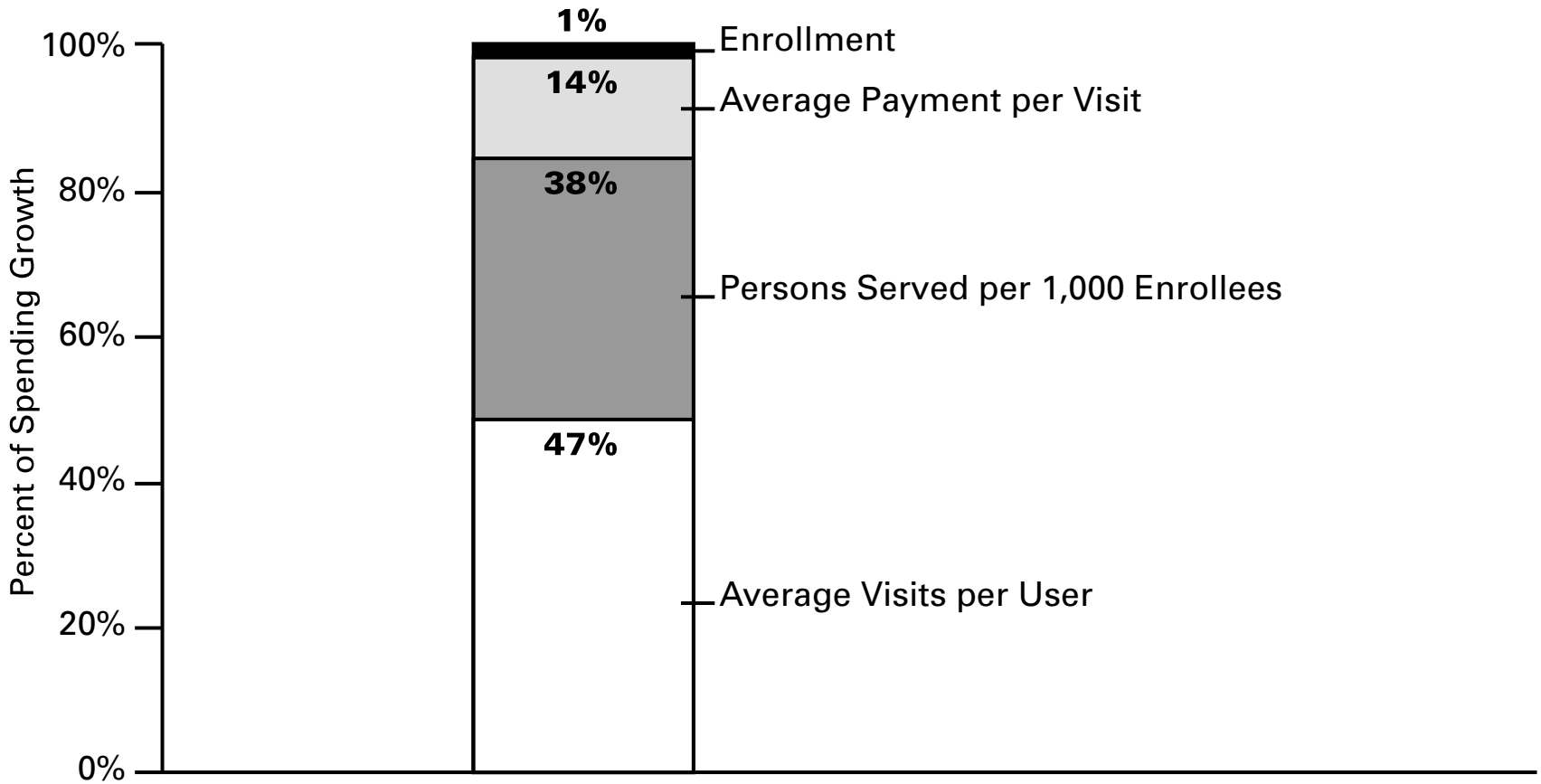


Note: ADL = Activities of Daily Living (e.g., bathing, eating). IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Figure 3.8 Components of Medicare Home Health Spending Growth, 1990–1997

Home health spending has increased largely because of growth in the average number of visits per user and in the proportion of beneficiaries using home health.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series. Data development by the Office of the Actuary, National Health Statistics Group.

Medicare Home Health Agency Statistics

SECTION 4

4. Medicare Home Health Agency Statistics

Over time, the composition of the home health industry has changed. Once limited to public and non-profit agencies, more than half of the industry now consists of for-profit providers, known as proprietary agencies. The Omnibus Budget Reconciliation Act of 1980 played a role in this shift by removing restrictions on for-profit providers that limited their participation in the Medicare program. (See Section 6, A Medicare Home Health Primer.)

Along with the growth in home health utilization and spending, the number of Medicare-certified home health agencies increased substantially during the 1990s. The number of providers nearly doubled from 1990 to 1997. However, preliminary 1998 data show that the number of home health agencies dropped from 10,807 in 1997 to 9,376 in 1998, about the level of 1995. This decline reflects consolidation in the home health industry, including agency mergers and closures. Medicare's program integrity activities, such as the four-month moratorium on new agencies imposed in September 1997, and the legislative changes to the home health benefit in the Balanced Budget Act of 1997 have contributed to the industry consolidation.

The drop in the number of agencies has generated concern about beneficiary access to home health. In light of these concerns, the Health Care Financing Administration (HCFA) is monitoring the impact of the Balanced Budget Act. The General Accounting Office (GAO) also has assessed the impact of the decrease in home health agencies. In two separate reports, GAO concluded that beneficiary access to home health services has not been significantly affected by the decline in the number of agencies.[1]

In addition, the Medicare Payment Advisory Commission (MedPAC) recently conducted a study on access to home health. In its June 1999 report, MedPAC stated, "Regardless of the causes, it is too early to assess the appropriateness of declines in agency supply. The Commission views some decline as an appropriate response to the rapid increase in home health agencies and service use during the 1990s."[2]

- **Number and Type of Home Health Agencies (Figure 4.1).** Although the total number Medicare-certified agencies declined in 1998, there was rapid growth in the industry for most of the decade. From 1990 to 1997, the total number of home health agencies increased from 5,708 to 10,807. Proprietary agencies grew from 36 percent of total agencies in 1990 to 58 percent in 1997. In contrast, voluntary non-profit and government affiliated providers as a share of total agencies fell from 1990 to 1997.

- **Number of Home Health Agencies per 10,000 Medicare Enrollees (Figure 4.2).** The number of agencies per 10,000 Medicare fee-for-service enrollees provides some measure of capacity to serve patients. This number rose from 1.8 in 1990 to 3.3 in 1997, an 83 percent increase. Between 1997 and 1998, the number of agencies per 10,000 enrollees declined 12 percent to 2.9, the level of 1996. Taking into account the 1997 to 1998 decrease, the number of agencies per 10,000 enrollees still increased by 61 percent from 1990 to 1998.

[1] General Accounting Office. GAO/HEHS-98-238 *Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services.* September 1998.

General Accounting Office. GAO/HEHS-99-120 *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired.* May 1999.

[2] Medicare Payment Advisory Commission. *Report to the Congress: Selected Medicare Issues,* "Access to home health services." June 1999, p. 112.

- **Weekly Hours Worked by Home Health Employees (Figure 4.3).** A better measure of capacity to serve patients is weekly hours worked per 10,000 Medicare fee-for-service enrollees. From 1990 to 1997, the weekly hours worked per 10,000 enrollees by non-supervisory employees at freestanding agencies[4] increased 172 percent, from 2,107 to 5,734. Data from 1997 through March 1999 show a decline of 7 percent in weekly hours worked, to roughly the 1996 level. This decline may reflect the decrease in the number of Medicare-certified home health agencies during a similar period. Note however, that weekly hours worked more than doubled, from 1990 through March 1999.

- **Employment Growth (Figure 4.4).** Employment at freestanding home health agencies jumped 143 percent from the first quarter of 1990 through the first quarter of 1999. In contrast, employment in health services increased only 29 percent while total U.S. private employment rose 18 percent during the same period. The increase in employment for home health agencies is consistent with the growth in home health spending and utilization. (See Section 2, Home Health Utilization, and Section 3, Home Health and Medicare Spending.)

- **Number of Home Health Visits by Type of Agency (Figure 4.5).** As noted elsewhere, the average number of home health visits per user climbed rapidly during the past decade. Home health agencies provided an average of 73 visits during 1997, more than tripling the average number provided in 1987 (not shown on chart).

  Little variation existed between the types of agencies regarding utilization in 1987. However, by 1997, the average number of visits per user differed considerably by type of home health provider: proprietary agencies — 104; government agencies — 60; voluntary agencies — 53. The reasons for the variation are unclear. In a 1996 study, the General Accounting Office noted that the difference in visit levels is not fully explained by patients' diagnoses.[5]

- **Distribution of Home Health Visits, by Type of Visit and Type of Agency (Figure 4.6).** The use of Medicare home health has shifted from skilled care to a nearly equal combination of skilled care and home health aide visits. During 1987, 66 percent of all visits were for skilled care while 33 percent were for home health aides. By 1997, skilled care visits comprised 51 percent of all visits and home health aides accounted for 48 percent of all visits.

- **Medicare Home Health Payments by Type of Agency (Figure 4.7).** From 1987 to 1997, Medicare payments to home health agencies increased from $2.6 billion (1997 dollars) to $16.7 billion (not shown on chart). During that period, the share of program payments to government and non-profit agencies fell, while the share to proprietary providers significantly increased.

- **Visit Charges by Type of Agency (Figure 4.8).** For all home health agencies, the average charges submitted for a visit ranged from $64 for home health aide services to $147 for medical social services.[6] Government affiliated providers charged the lowest amount for all types of visits in 1997. For-profit agencies billed the highest visit charges.

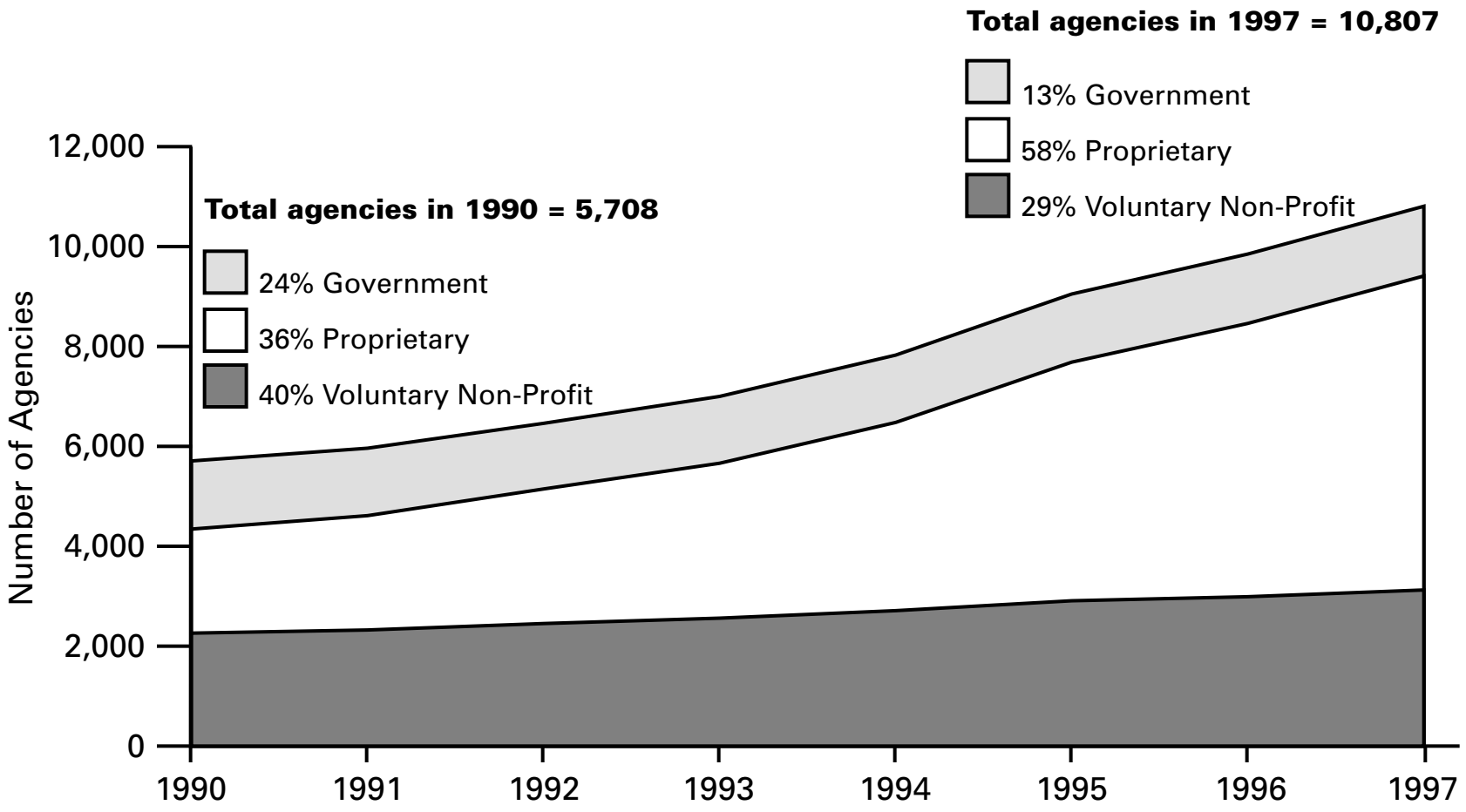
[4] Home health providers that are not associated with a hospital or nursing home are known as freestanding agencies. They represent a majority of home health providers, 73 percent in 1997.

[5] General Accounting Office. GAO/HEHS-96-16 *Medicare: Home Health Utilization Expands While Program Controls Deteriorate*. March 1996.

[6] Visit charges reflect home health agency claims as submitted, not final Medicare payment.

Figure 4.1 Number and Type of Medicare Home Health Agencies, 1990–1997

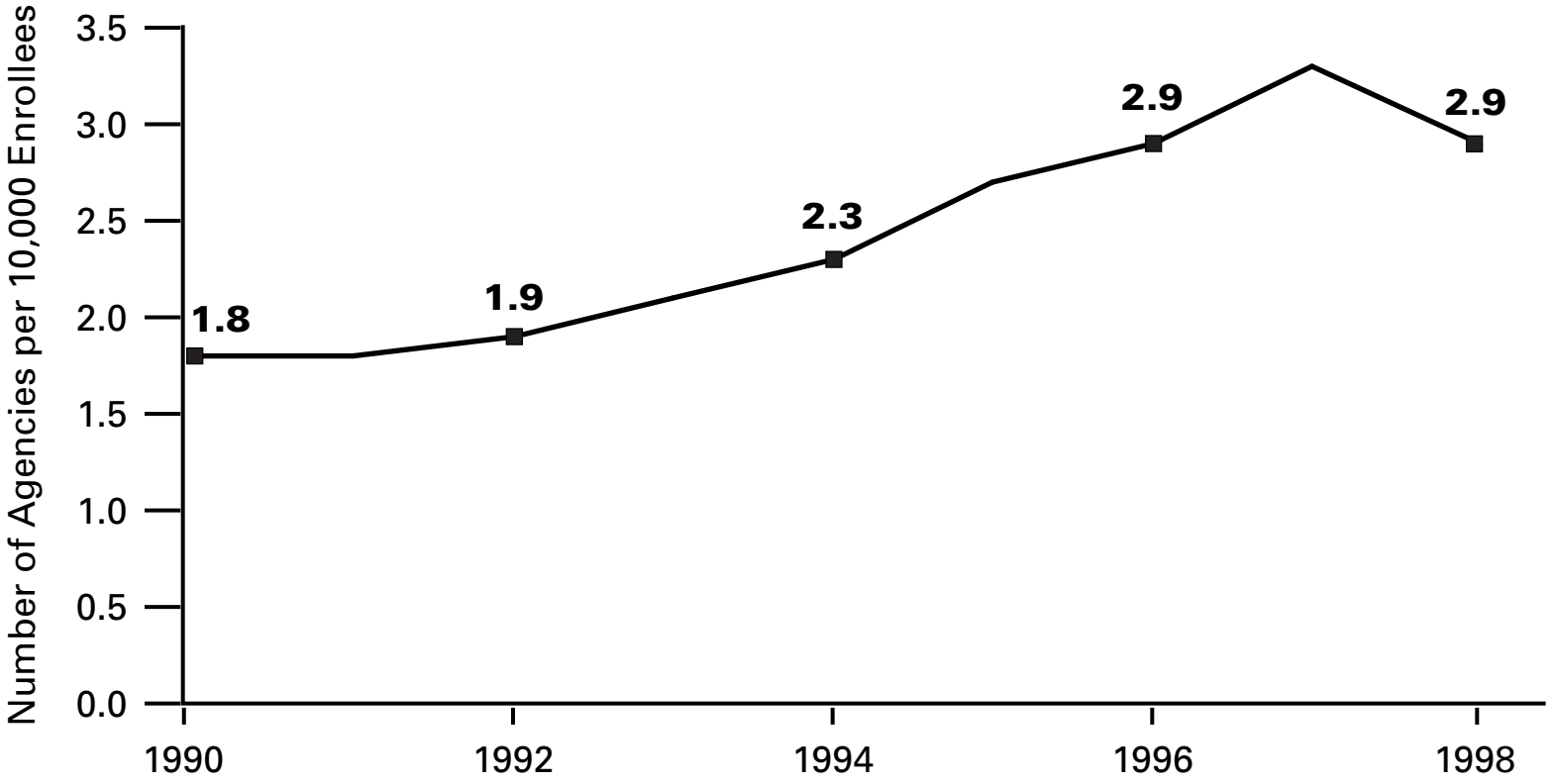
The number of proprietary agencies has grown dramatically since 1990, surpassing voluntary non-profits as the most common type of agency.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 4.2 Number of Home Health Agencies per 10,000 Medicare Fee-for-Service Enrollees, 1990–1998

A measure of capacity to serve patients, the number of agencies per 10,000 Medicare enrollees, increased by more than half from 1990–1998, even when accounting for the decline between 1997 and 1998.

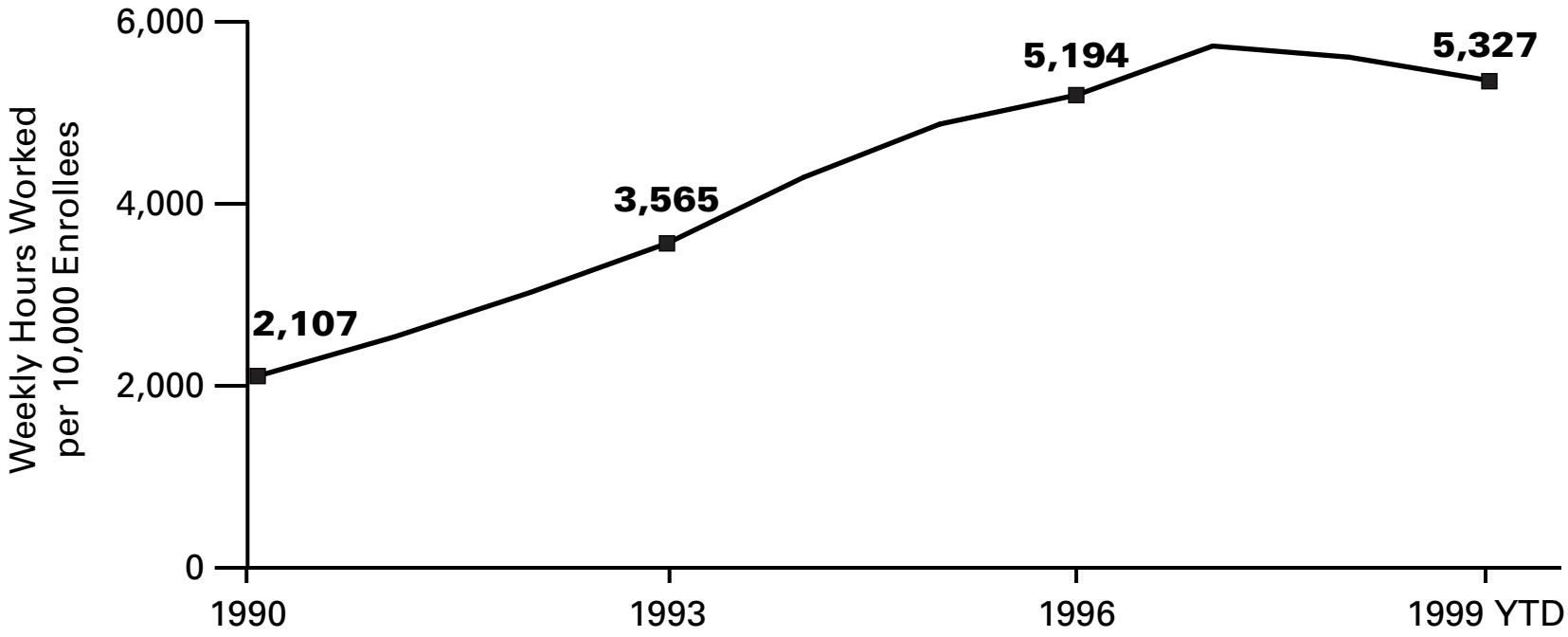


Note: In 1997, the number of agencies per 10,000 fee-for-service (FFS) enrollees was 3.3.

Source: Number of agencies and Medicare FFS enrollment 1990 through 1998 — HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series. 1998 number of agencies — HCFA, Online Survey and Certification Reporting System.

Figure 4.3 Weekly Hours Worked by Home Health Employees per 10,000 Medicare Fee-for-Service Enrollees, 1990–1999 Year to Date (YTD)

Aggregate hours for 1999 YTD are at levels comparable to 1996, and show a 146 percent increase since 1990.

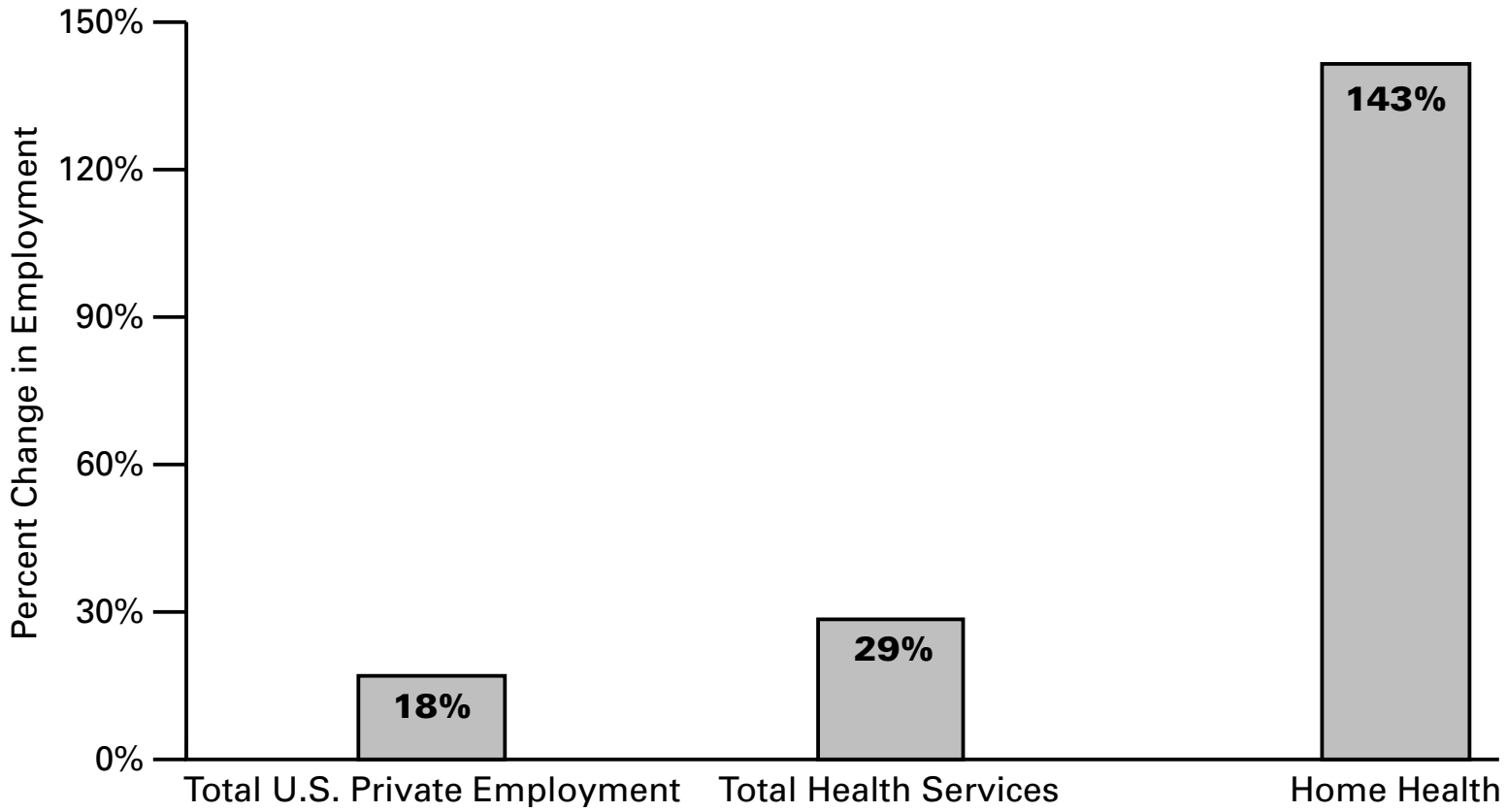


Note: Yearly averages are used to compute weekly hours per 10,000 fee-for-service (FFS) enrollees. The 1999 YTD average is based on hours worked data from January through March and 1998 FFS enrollment. In 1997 weekly hours worked per 10,000 enrollees was 5,734. Weekly hours worked refer to freestanding agencies and include non-supervisory employees only.

Source: Hours worked — U.S. Department of Labor, Bureau of Labor Statistics, Current Employment Statistics, 6/4/99. FFS enrollment — HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 4.4 Employment Growth by Type of Employment, First Quarter 1990 to First Quarter 1999

The growth in home health employment is substantially larger than the growth in health services employment and U.S. private employment overall.

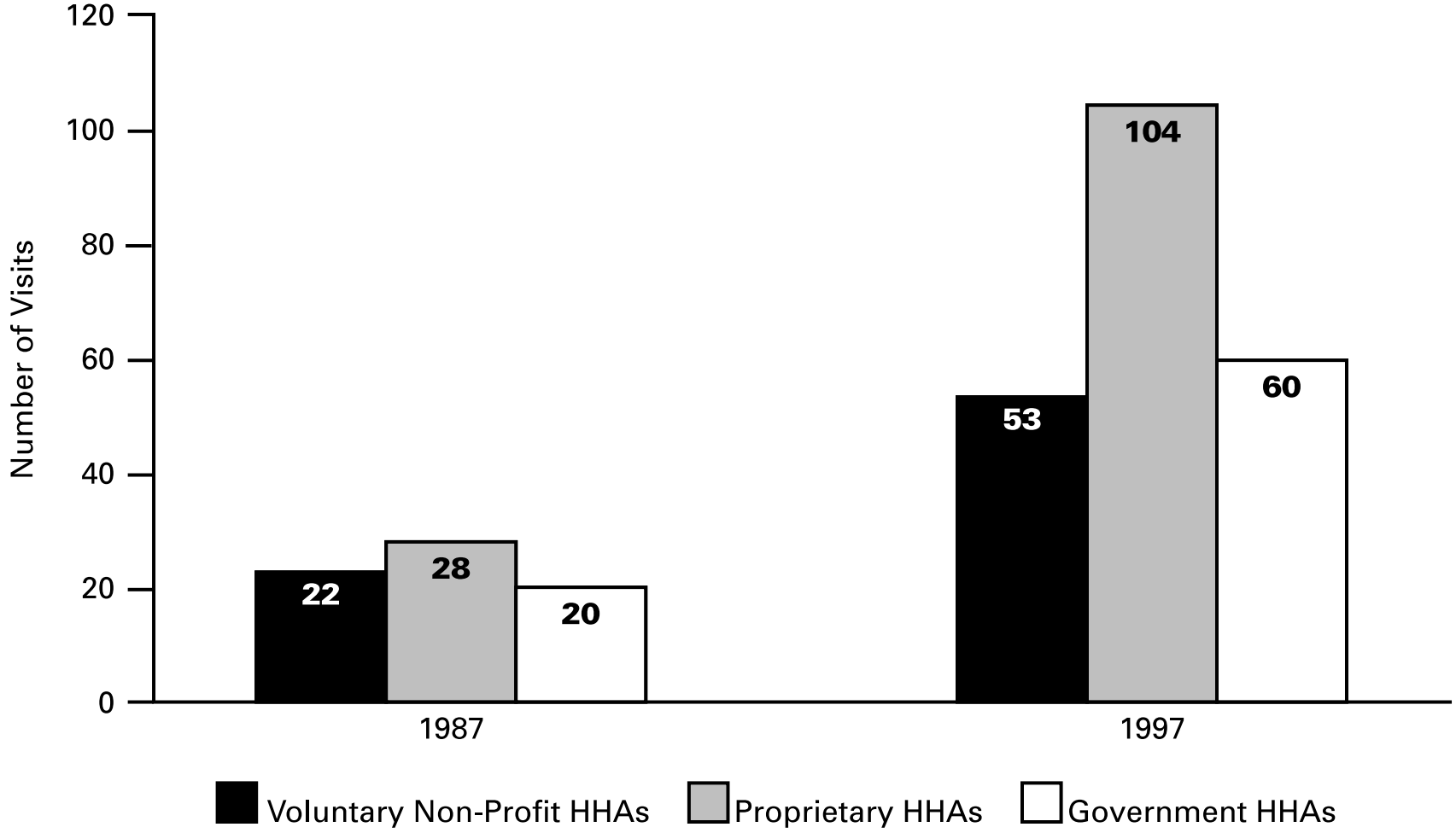


Note: Home health data only refer to freestanding home health agencies.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Current Employment Statistics, 6/4/99.

Figure 4.5 Average Number of Visits per Home Health User by Type of Agency, 1987 and 1997

Proprietary agencies now provide more visits per user than voluntary or government agencies.



Note: HHAs = Home Health Agencies.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 4.6 Distribution of Home Health Visits by Type of Visit and Type of Agency, 1987 and 1997

The mix of visits has changed for all types of agencies.

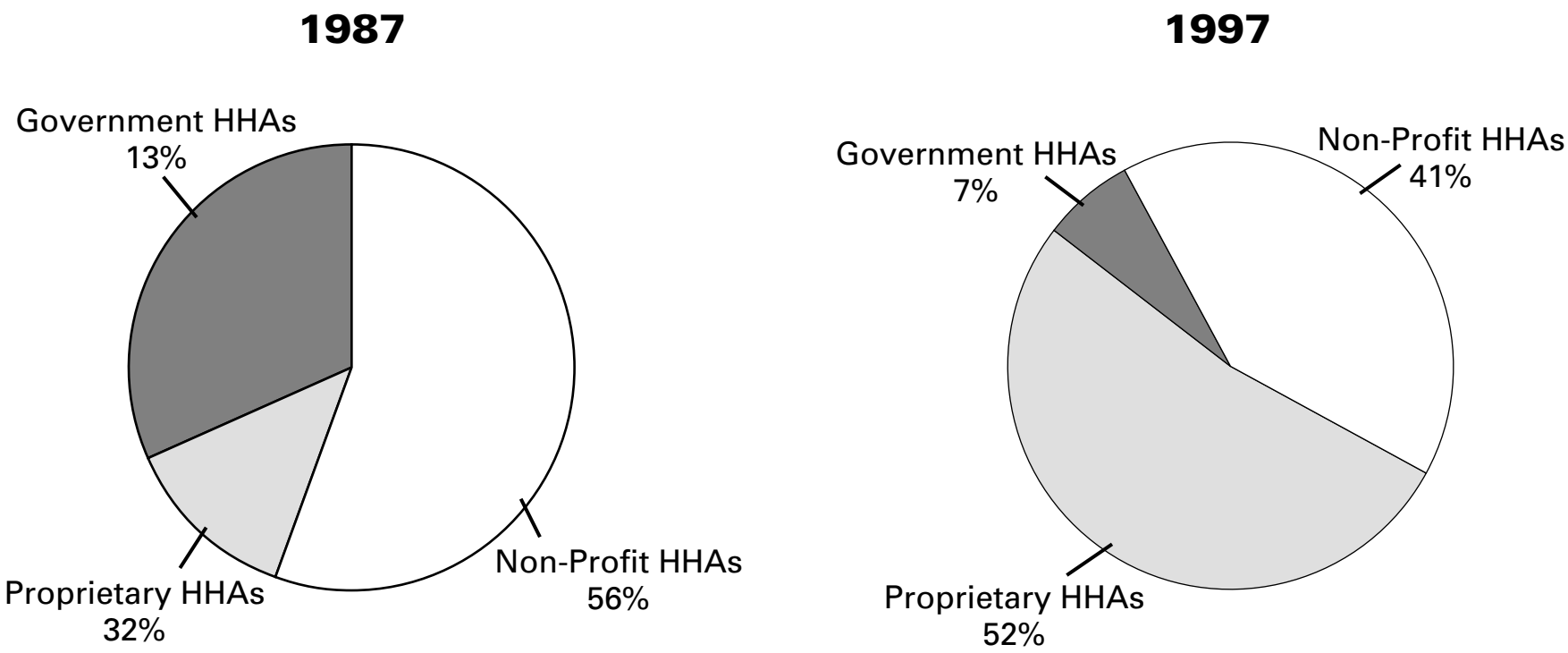
	1987			1997		
	Skilled Visits	Home Health Aide Visits	Other	Skilled Visits	Home Health Aide Visits	Other
Voluntary Non-Profit	69%	30%	1%	55%	44%	1%
Proprietary	62%	37%	1%	49%	51%	1%
Government	64%	35%	1%	48%	51%	1%
All HHAs	66%	33%	1%	51%	48%	1%

Note: HHAs = Home Health Agencies. "Skilled visits" include physical, speech and occupational therapy visits as well as skilled nursing visits. "Other" includes medical social services such as patient counseling. Certain rows may not sum to 100 due to rounding.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 4.7 Medicare Home Health Payments by Type of Agency, 1987 and 1997

The share of home health payments to different types of agencies has changed over time.



Note: HHAs = Home Health Agencies. Percentages may not sum to 100 due to rounding.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 4.8 Average Visit Charges by Type of Home Health Agency, 1997

Average visit charges vary by type of visit and by type of agency.

	Average Charge by Visit Type, all HHAs	Voluntary Non-Profit	Proprietary	Government
Skilled Nursing	$109	$106	$113	$95
Physical Therapy	$114	$110	$120	$100
Speech Therapy	$115	$112	$120	$101
Occupational Therapy	$115	$112	$121	$105
Medical Social Services	$147	$142	$153	$134
Home Health Aide	$64	$63	$67	$55
Other Services	$84	$83	$87	$82
Average Visit Charge by Type of HHA	$88	$87	$90	$75

Note: HHAs = Home Health Agencies. Visit charges reflect unpaid claims, not final Medicare payment. "Medical social services" include patient counseling and assessments of community resources availability. "Other services" include durable medical equipment and medical supplies, such as sterile dressings.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Medicare Home Health Data by State

SECTION 5

5. Medicare Home Health Data by State

As with other Medicare services, there is wide variation in the use of home health services across states. In 1997, the percent of Medicare beneficiaries receiving home health ranged from 5 to 16 percent across states. The average number of visits per home health patient ranged from a low of 32 to a high of 161. Average home health payments per patient also varied by more than threefold.

Reasons for the extraordinary difference in home health use across states are unknown. Characteristics of Medicare beneficiaries, such as age, gender, and functional status, across geographic areas do not fully explain the differences.[1] However, there are some factors that may play a role in the variation. Differences in the business practices of home health agencies in their markets may be factor. The cultural preferences of beneficiaries and the practices of physicians prescribing home health also may contribute to the geographic variation.

Another factor may be the relationship between Medicare and Medicaid home health spending. Studies have shown that, to a degree, certain states are substituting Medicare home health for Medicaid home health. (Schore;[2] Cohen and Tumlinson;[3] and Kenney et al.[4]) These states tend to exhibit high Medicare and low Medicaid home health spending.

- **States with the Lowest and Highest Home Health Spending per User (Figure 5.1).** Medicare home health payments per user varied significantly across the country, ranging from $2,561 in Iowa to over 3 times that amount in Louisiana. Payments averaged under $3,500 in about one-third of the states. In about one-fifth of the states, payments averaged over $5,000. (See the appendix to this section, Figure A.1 for average home health payments and visits per user by state for selected years).

- **Home Health Spending as a Share of Total Medicare Expenditures (Figure 5.2).** The proportion of total Medicare expenditures devoted to home health services averaged 10 percent for the U.S. The number ranged from a low of 4 to a high of 23 percent across states in 1996 (latest data available for total Medicare expenditures by state.) In seven states, mostly clustered in the North Central region, home health spending as a share of statewide Medicare expenditures was 5 percent or less. In contrast, Medicare home health spending made up more than 15 percent of total Medicare expenditures in six states.

- **Home Health Use (Figure 5.3).** The percent of Medicare beneficiaries using home health services increased in every state from 1990 to 1997. (See Appendix, Figure A.2.) By 1997, over 10 percent of beneficiaries were receiving home health in 21 states.

- **State Classification Based on Medicare and Medicaid Home Care Spending (Figure 5.4).**[5] Recent research examined Medicare and Medicaid home care spending by state and identified a weak but significant, indirect relationship between these payors. Most states, 30, fell into one of two groups— high

[1] Mauser, Elizabeth and Miller, Nancy A., "A Profile of Home Health Users in 1992," *Health Care Financing Review* (Volume 16, Number 1, Fall 1994): 23-24.

[2] Schore, Jennifer, "Regional Variation in the Use of Medicare Home Health Services," *Persons with Disabilities, Issues in Health Care Financing and Service Delivery* (1995): 267-290.

[3] Cohen, Marc and Tumlinson, Anne, "Understanding the State Variation in Medicare Home Health Care, The Impact of Medicaid Program Characteristics, State Policy, and Provider Attributes," *Medical Care* (Volume 35, Number 6, 1997): 618-633.

[4] Kenney, Genevieve, Rajan, Shruti and Soscia, Stephanie, "State Spending for Medicare and Medicaid Home Care Programs," *Health Affairs* (January/February 1998): 201-212.

[5] *Ibid*.

Medicare and low Medicaid home care spending, or vice versa. Fifteen states fit the pattern of high Medicare/low Medicaid. These states tended to be in the South. The other 15 states fell into the low Medicare/high Medicaid group. These states were more dispersed geographically.

- **Change in the Number of Home Health Agencies in Selected States and Change in Home Health Employment (Figures 5.5 and 5.6).** The total number of home health agencies declined from 10,807 in 1997 to 9,376 in 1998 (not shown on chart). The decrease includes both agency closures and agency mergers. Over half of the roughly 1,400 closure/mergers occurred in four states: California, Louisiana, Oklahoma and Texas. From 1990 to 1997, these four states experienced some of the largest growth in the number of agencies across the country. (See Appendix, Figure A.3 for data on the number of home health agencies by state for selected years.)

  Attention has been focused on agency closings. However, because closings can be associated with mergers, and staff can move to other agencies, employment data is perhaps a better measure of the capacity to serve patients than the number of agencies by itself.

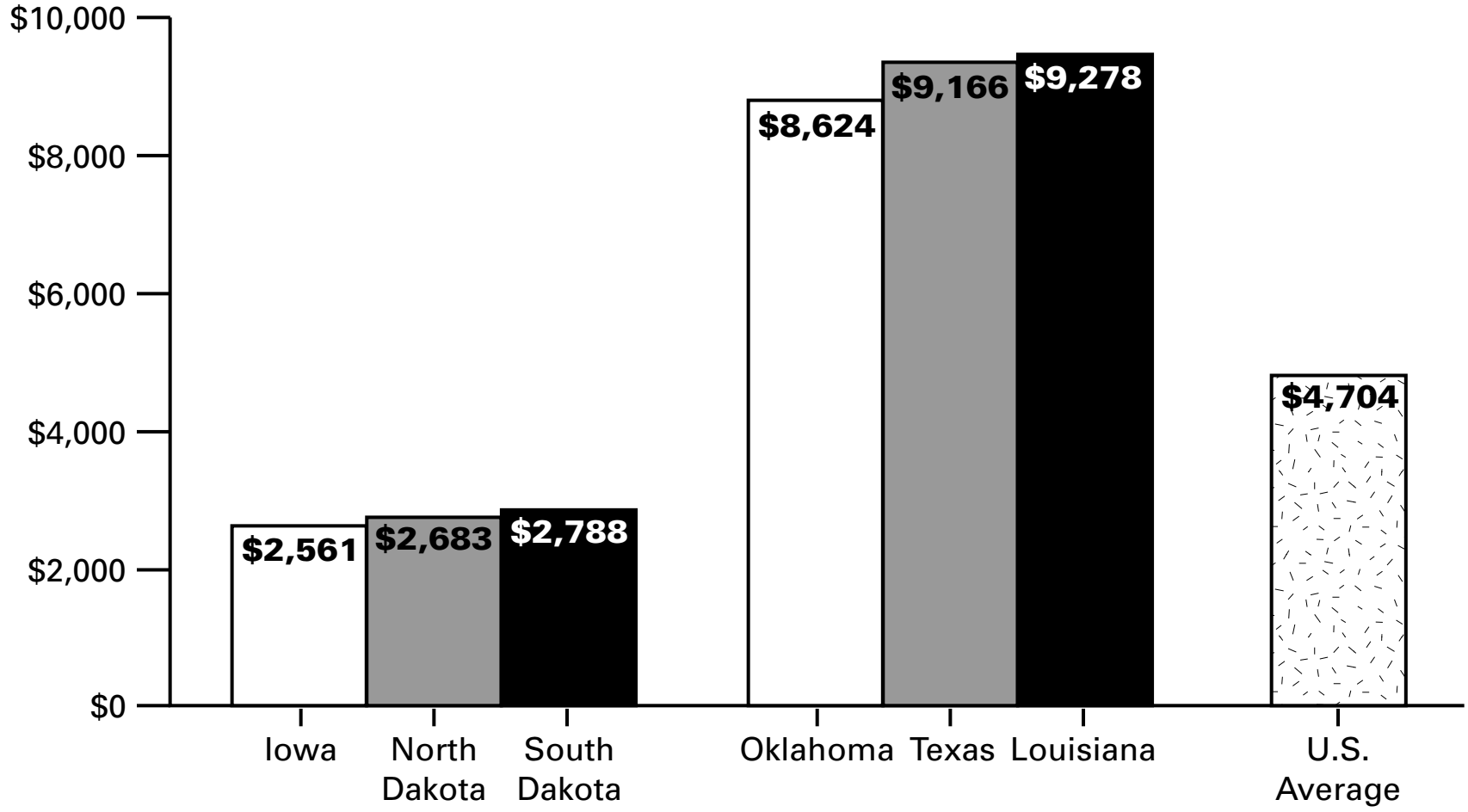
For example, there are six states (Delaware, Hawaii, Mississippi, New Jersey, Tennessee and Vermont) where the number of agencies in 1998 was below 1990 levels, a time before the rapid expansion in Medicare home health (See Appendix, Figure A.3). All of these states, with the exception of Hawaii, were experiencing drops in the number of agencies between 1990 and 1994. Yet the percent of beneficiaries using home health increased in all of these states from 1990 to 1994 (See Appendix, Figure A.2). During the same period, the number of home health employees also rose in these states, except for the two states where 1990 data are unavailable, Hawaii and New Jersey (See Appendix, Figure A.4).

From 1990 to 1997 (latest data available), employment at freestanding home health agencies[6] generally increased (Figure 5.6). For all states with available data from 1990 to 1997, the number of home health employees at freestanding agencies rose, except in North Dakota. North Dakota experienced a 9 percent decline in this number. However, from 1990 to 1997, North Dakota experienced growth in the number of facility-based agencies. Although employment data for such agencies are not available, the total number of home health employees may not have declined given the growth in facility-based agencies.

[6] Home health providers that are not associated with a hospital or nursing home are known as freestanding agencies. They represent a majority of home health providers, 73 percent in 1997. Agencies that are associated with a hospital or nursing home are known as facility-based agencies. These agencies accounted for 27 percent of all home health providers in 1997.

Figure 5.1 Average Medicare Home Health Payment per User in Selected States, 1997

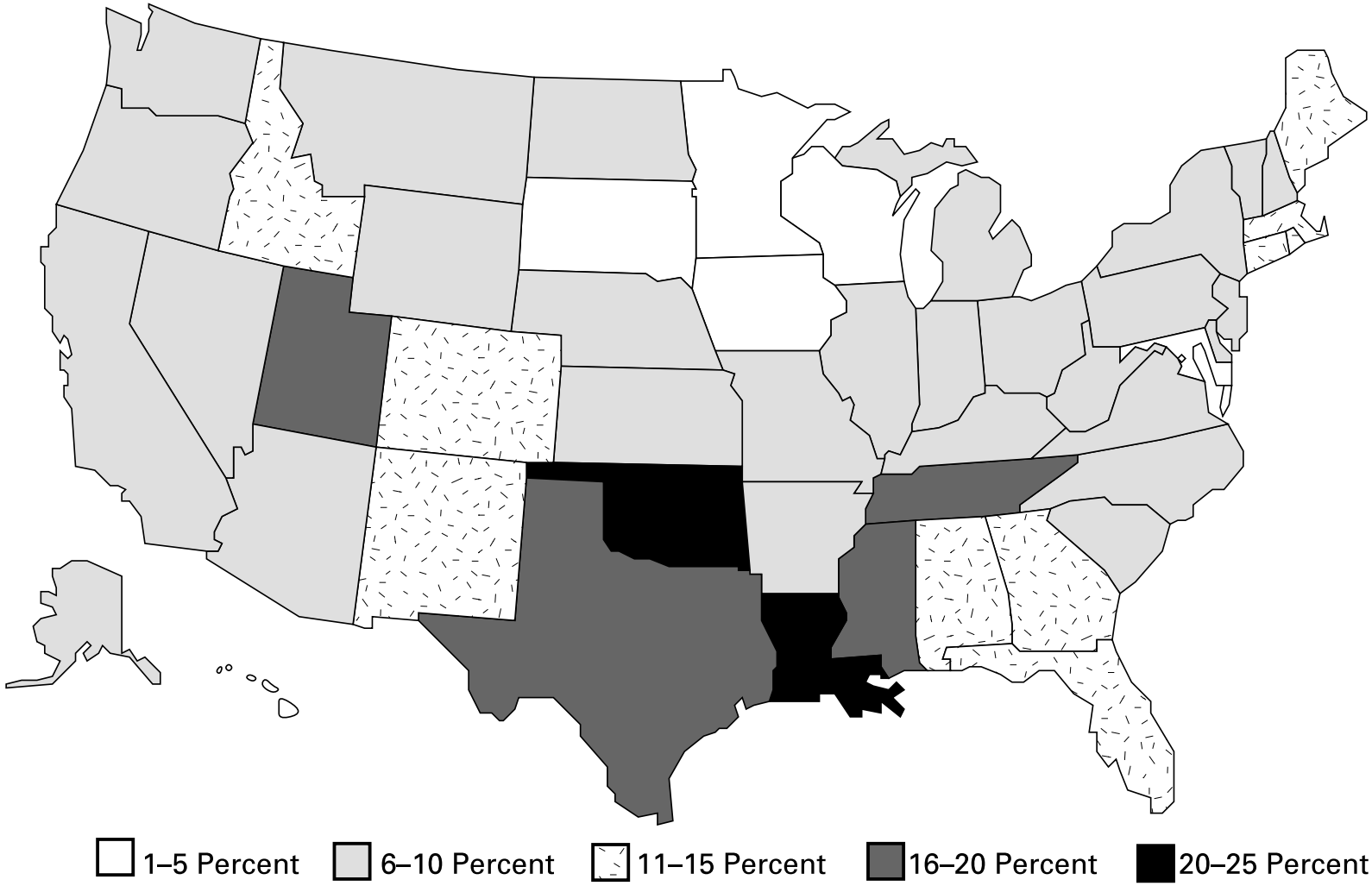
Comparing the three states with the lowest and the highest home health payments illustrates the geographic variation in the benefit.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 5.2 Home Health Spending as a Share of Total Medicare Expenditures, 1996

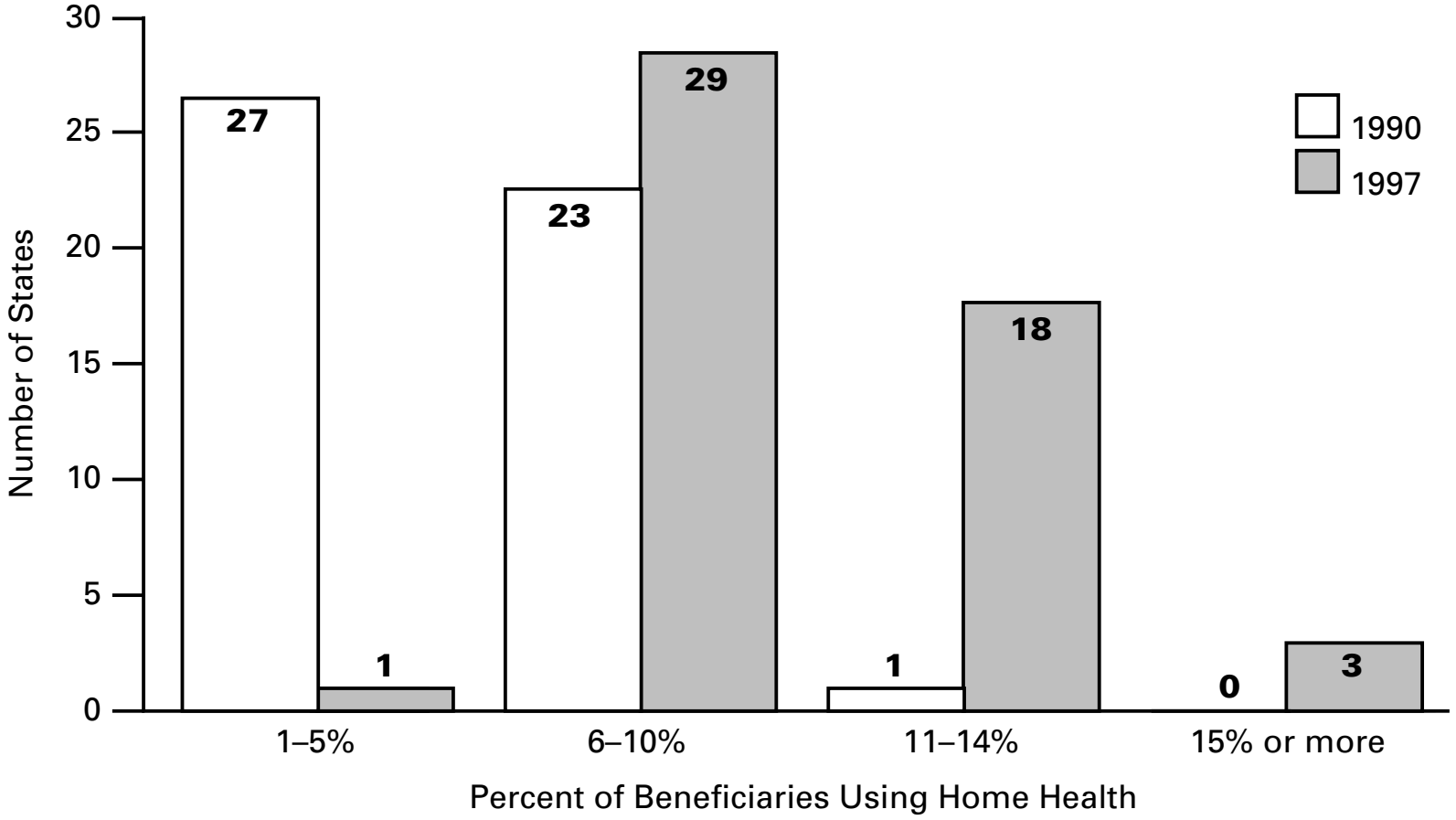
Home health payments as a share of total Medicare expenditures vary across the U.S.



Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 5.3 Distribution of States by Level of Home Health Use, 1990 and 1997

In 21 states, over 10 percent of Medicare beneficiaries used home health in 1997; only one state had this level of utilization in 1990.



Note: Nationwide, 5.8 percent of beneficiaries used home health in1990. In 1997, 10.8 percent of beneficiaries received home health. The District of Columbia is included in the data.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure 5.4 Categorization of States Based on Medicare and Medicaid Home Care Spending, 1993

Research has found a trade-off between Medicare and Medicaid home care spending.

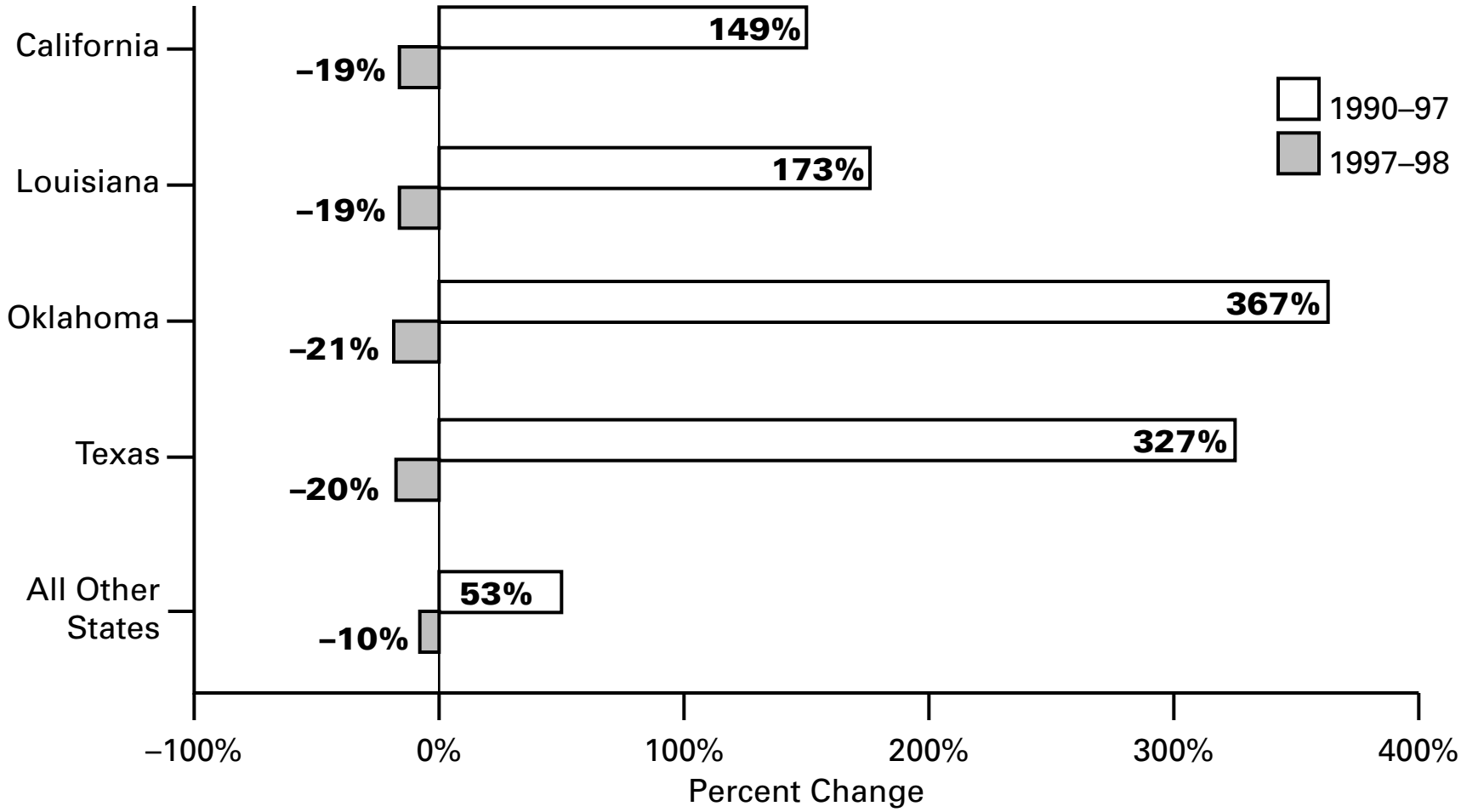
High Medicare/ High Medicaid	High Medicare/ Low Medicaid	Low Medicare/ High Medicaid	Low Medicare/ Low Medicaid
Arkansas	Alabama	Delaware	Alaska
Colorado	California	Kansas	District of Columbia
Connecticut	Florida	Maryland	Hawaii
Maine	Georgia	Michigan	Idaho
Massachusetts	Kentucky	Minnesota	Illinois
New Hampshire	Louisiana	Montana	Indiana
Rhode Island	Mississippi	Nebraska	Iowa
Utah	Missouri	New Jersey	New Mexico
Vermont	Nevada	New York	Ohio
Wyoming	North Carolina	North Dakota	Virginia
	Oklahoma	Oregon	
	Pennsylvania	South Dakota	
	South Carolina	Washington	
	Tennessee	West Virginia	
	Texas	Wisconsin	

Note: The authors found a significant but weak inverse relationship between Medicare and Medicaid home care spending. The study did not include Arizona.

Source: Kenney, Genevieve, Rajan, Shruti and Soscia, Stephanie, "State Spending for Medicare and Medicaid Home Care Programs," *Health Affairs* (January/February 1998): 207.

Figure 5.5 Percent Change in the Number of Home Health Agencies, Selected States, 1990–1997 and 1997–1998

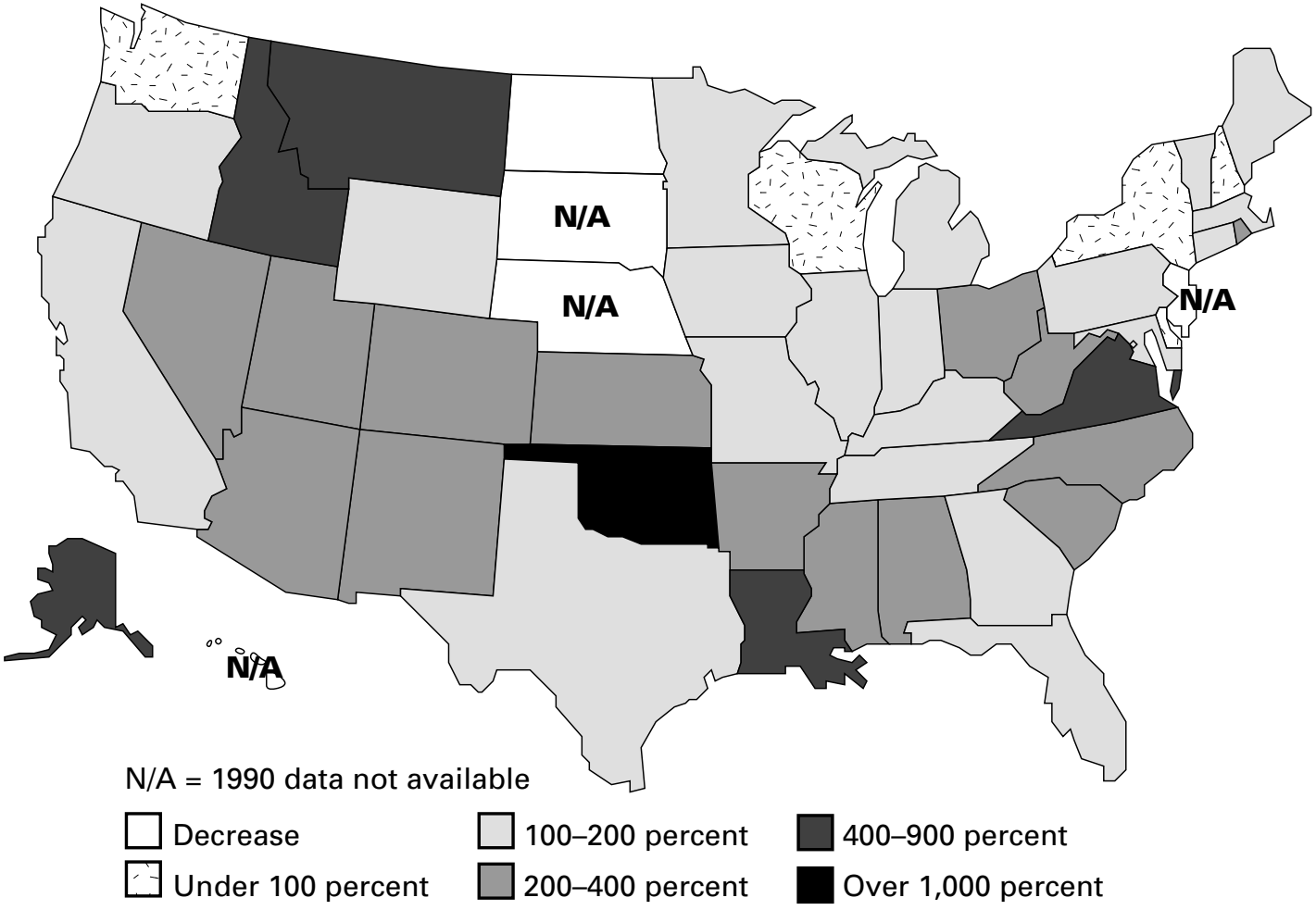
Over half of the 1,431 agency closure/mergers in 1998 occurred in four states that experienced some of the greatest growth in agencies from 1990 to 1997.



Source: 1990 and 1997 — HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series. 1998 — HCFA, Online Survey and Certification Reporting System, as of 1/7/99.

Figure 5.6 Percent Change in the Number of Home Health Employees, Between 1990 and 1997

In all states with available data, the number of employees at freestanding home health agencies increased, with the exception of North Dakota.



Source: U.S. Department of Labor, Bureau of Labor Statistics, State and Area Current Employment Statistics, as of 6/4/99.

Medicare Home Health Data by State

APPENDIX

Figure A.1 Average Number of Home Health Visits and Average Real Payment per Home Health User, Selected Years

	Average Visits per User				Average Real Home Health Payment per User			
	1990	1994	1997	Percent Change '90-'97	1990	1994	1997	Percent Change '90-'97
Alabama	64	113	121	89%	$3,213	$5,545	$6,072	89%
Alaska	22	43	46	109%	$2,719	$4,708	$4,966	83%
Arizona	35	56	59	69%	$2,559	$4,269	$4,340	70%
Arkansas	47	76	77	64%	$2,603	$3,894	$3,936	51%
California	23	46	49	113%	$2,150	$4,425	$4,440	107%
Colorado	32	60	67	109%	$2,442	$4,442	$4,759	95%
Connecticut	35	73	81	131%	$2,317	$4,742	$4,703	103%
Delaware	35	43	50	43%	$2,032	$2,691	$3,195	57%
District of Columbia	31	42	53	71%	$2,556	$3,759	$4,090	60%
Florida	43	76	75	74%	$2,674	$4,989	$5,186	94%
Georgia	57	102	99	74%	$3,218	$5,663	$5,583	73%
Hawaii	21	41	39	86%	$1,912	$3,854	$3,357	76%
Idaho	26	54	59	127%	$1,923	$3,634	$4,100	113%
Illinois	30	52	50	67%	$2,093	$3,677	$3,495	67%
Indiana	32	73	72	125%	$2,065	$4,343	$4,247	106%
Iowa	27	46	49	81%	$1,423	$2,476	$2,561	80%
Kansas	34	56	64	88%	$2,052	$3,785	$4,029	96%
Kentucky	40	65	74	85%	$2,368	$3,658	$4,158	76%
Louisiana	54	126	161	198%	$3,132	$7,275	$9,278	196%
Maine	34	64	68	100%	$2,243	$3,654	$3,732	66%

Figure A.1 Average Number of Home Health Visits and Average Real Payment per Home Health User, Selected Years *(continued)*

	Average Visits per User				Average Real Home Health Payment per User			
	1990	1994	1997	Percent Change '90-'97	1990	1994	1997	Percent Change '90-'97
Maryland	29	37	37	28%	$2,176	$3,104	$3,088	42%
Massachusetts	39	87	97	149%	$2,461	$4,699	$5,210	112%
Michigan	29	45	50	72%	$2,215	$3,567	$3,900	76%
Minnesota	22	38	47	114%	$1,476	$2,734	$3,078	109%
Mississippi	72	114	120	67%	$3,522	$5,772	$6,238	77%
Missouri	32	50	54	69%	$2,095	$3,432	$3,511	68%
Montana	35	52	52	49%	$2,196	$3,314	$3,452	57%
Nebraska	28	41	45	61%	$1,906	$2,786	$2,884	51%
Nevada	34	68	63	85%	$2,589	$4,849	$4,775	84%
New Hampshire	33	57	64	94%	$2,157	$3,065	$3,287	52%
New Jersey	25	40	43	72%	$1,571	$2,934	$3,189	103%
New Mexico	30	56	74	147%	$1,935	$3,643	$4,600	138%
New York	25	45	53	112%	$2,122	$3,620	$3,924	85%
North Carolina	35	57	55	57%	$2,459	$3,569	$3,552	44%
North Dakota	27	42	43	59%	$1,593	$2,584	$2,683	68%
Ohio	27	51	50	85%	$1,783	$3,273	$3,194	79%
Oklahoma	46	106	147	220%	$2,887	$6,553	$8,624	199%
Oregon	23	40	34	48%	$2,028	$3,462	$3,020	49%
Pennsylvania	29	43	47	62%	$2,061	$3,148	$3,418	66%
Rhode Island	35	61	72	106%	$2,399	$4,075	$4,727	97%

Figure A.1 Average Number of Home Health Visits and Average Real Payment per Home Health User, Selected Years *(continued)*

	Average Visits per User				Average Real Home Health Payment per User			
	1990	1994	1997	Percent Change '90-'97	1990	1994	1997	Percent Change '90-'97
South Carolina	32	67	63	97%	$2,374	$4,087	$4,035	70%
South Dakota	23	39	48	109%	$1,526	$2,608	$2,788	83%
Tennessee	68	116	109	60%	$4,058	$7,067	$6,496	60%
Texas	43	97	141	228%	$2,748	$6,490	$9,166	234%
Utah	48	98	115	140%	$2,891	$5,951	$7,180	148%
Vermont	37	61	68	84%	$2,185	$2,861	$3,004	38%
Virginia	35	49	57	63%	$2,398	$3,440	$3,814	59%
Washington	24	38	32	33%	$1,993	$4,290	$2,830	42%
West Virginia	34	51	60	76%	$2,036	$3,061	$3,623	78%
Wisconsin	26	42	43	65%	$1,686	$2,808	$2,885	71%
Wyoming	31	77	72	132%	$2,052	$4,679	$4,130	101%
United States	36	66	73	103%	$2,364	$4,329	$4,704	99%

Note: Payment is in 1997 dollars. The home health input price index is the deflator. These payments are not the interim payment system rates.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure A.2 Home Health Users as a Percent of Medicare Fee-for-Service Enrollees, Selected Years

	1990	1994	1997	Percent Change 1990-1997
Alabama	7	12	13	86%
Alaska	3	6	7	133%
Arizona	3	7	8	167%
Arkansas	6	10	11	83%
California	6	10	11	83%
Colorado	5	9	10	100%
Connecticut	7	11	13	86%
Delaware	6	9	9	50%
District of Columbia	5	8	9	80%
Florida	7	12	12	71%
Georgia	6	11	11	83%
Hawaii	2	4	5	150%
Idaho	4	8	10	150%
Illinois	6	9	11	83%
Indiana	5	8	10	100%
Iowa	4	7	8	100%
Kansas	4	7	9	125%
Kentucky	6	9	12	100%
Louisiana	8	14	16	100%
Maine	6	10	12	100%

Figure A.2 Home Health Users as a Percent of Medicare Fee-for-Service Enrollees, Selected Years *(continued)*

	1990	1994	1997	Percent Change 1990-1997
Maryland	6	8	9	50%
Massachusetts	7	13	15	114%
Michigan	6	9	10	67%
Minnesota	3	6	7	133%
Mississippi	11	14	15	36%
Missouri	7	11	12	71%
Montana	5	7	9	80%
Nebraska	4	7	8	100%
Nevada	5	7	9	80%
New Hampshire	7	11	12	71%
New Jersey	5	8	10	100%
New Mexico	5	8	10	100%
New York	5	8	9	80%
North Carolina	5	9	10	100%
North Dakota	4	7	8	100%
Ohio	5	8	10	100%
Oklahoma	6	11	13	117%
Oregon	4	8	9	125%
Pennsylvania	7	10	13	86%
Rhode Island	6	11	14	133%

Figure A.2 Home Health Users as a Percent of Medicare Fee-for-Service Enrollees, Selected Years *(continued)*

	1990	1994	1997	Percent Change 1990-1997
South Carolina	5	8	10	100%
South Dakota	3	6	8	167%
Tennessee	10	13	13	30%
Texas	6	11	13	117%
Utah	6	10	10	67%
Vermont	10	13	14	40%
Virginia	5	8	10	100%
Washington	5	7	8	60%
West Virginia	5	9	11	120%
Wisconsin	4	6	7	75%
Wyoming	3	9	9	200%
United States	6	9	11	83%

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

Figure A.3 Number of Home Health Agencies and Percent Growth, Selected Years

	1990	1994	1997	1998	Percent Change 1990-1998
Alabama	119	172	181	181	52%
Alaska	9	21	27	18	100%
Arizona	58	96	138	112	93%
Arkansas	168	203	205	197	17%
California	353	632	878	714	102%
Colorado	110	157	213	161	46%
Connecticut	97	115	116	101	4%
Delaware	20	19	20	18	–10%
District of Columbia	14	19	23	22	57%
Florida	245	302	390	369	51%
Georgia	72	81	98	100	39%
Hawaii	23	26	28	21	–9%
Idaho	28	56	80	64	129%
Illinois	248	320	396	361	46%
Indiana	133	211	308	261	96%
Iowa	151	177	220	195	29%
Kansas	124	167	228	193	56%
Kentucky	102	107	109	113	11%
Louisiana	191	430	521	424	122%
Maine	22	29	53	46	109%

Figure A.3 Number of Home Health Agencies and Percent Growth, Selected Years *(continued)*

	1990	1994	1997	1998	Percent Change 1990-1998
Maryland	73	74	81	77	5%
Massachusetts	147	172	212	187	27%
Michigan	161	177	241	220	37%
Minnesota	195	226	270	261	34%
Mississippi	79	76	69	69	–13%
Missouri	182	235	284	224	23%
Montana	45	52	62	60	33%
Nebraska	44	65	87	77	75%
Nevada	24	42	57	42	75%
New Hampshire	37	39	44	43	16%
New Jersey	57	53	57	55	–4%
New Mexico	48	80	120	96	100%
New York	202	211	228	223	10%
North Carolina	130	149	163	174	34%
North Dakota	30	33	36	35	17%
Ohio	237	355	486	425	79%
Oklahoma	84	238	392	310	269%
Oregon	60	81	92	75	25%
Pennsylvania	244	315	391	373	53%
Rhode Island	14	19	32	29	107%

Figure A.3 Number of Home Health Agencies and Percent Growth, Selected Years *(continued)*

	1990	1994	1997	1998	Percent Change 1990-1998
South Carolina	47	65	81	78	66%
South Dakota	16	36	57	52	225%
Tennessee	253	237	238	207	–18%
Texas	462	776	1,973	1,580	242%
Utah	37	66	92	72	95%
Vermont	16	13	13	13	–19%
Virginia	156	202	237	227	46%
Washington	54	61	70	66	22%
West Virginia	59	67	94	88	49%
Wisconsin	150	171	188	166	11%
Wyoming	33	55	57	56	70%
United States	5,708	7,827	10,807	9,376	63%

Note: United States total includes Puerto Rico, the Virgin Islands and Guam.

Source: 1990, 1994 and 1997 — HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series. 1998 — HCFA, Online Survey Certification and Reporting system, as of 1/7/99.

Figure A.4 Number of Home Health Employees

	1990	1994	1997	Percent Change 1990-1997
Alabama	3,183	8,823	10,047	216%
Alaska	27	339	245	807%
Arizona	1,135	4,538	5,133	352%
Arkansas	1,067	2,405	3,968	272%
California	14,729	23,358	35,299	140%
Colorado	2,664	5,661	8,818	231%
Connecticut	6,025	13,280	15,882	164%
Delaware	1,086	1,500	2,014	85%
District of Columbia	563	1,027	1,421	152%
Florida	18,315	43,902	42,660	133%
Georgia	5,969	15,090	15,496	160%
Hawaii	—	825	1,118	—
Idaho	337	1,427	1,946	477%
Illinois	8,582	18,955	21,130	146%
Indiana	6,364	11,753	14,021	120%
Iowa	2,174	3,692	4,709	117%
Kansas	1,126	2,795	4,920	337%
Kentucky	3,378	6,865	8,960	165%
Louisiana	2,601	13,118	19,839	663%
Maine	1,551	3,054	3,427	121%

Figure A.4 Number of Home Health Employees *(continued)*

	1990	1994	1997	Percent Change 1990-1997
Maryland	2,354	4,997	6,725	186%
Massachusetts	11,222	26,085	30,869	175%
Michigan	8,044	19,117	22,777	183%
Minnesota	4,133	8,830	10,283	149%
Mississippi	2,311	6,129	7,526	226%
Missouri	6,420	10,348	13,694	113%
Montana	333	1,613	1,947	485%
Nebraska	—	—	1,319	—
Nevada	617	2,319	2,349	281%
New Hampshire	1,767	2,743	2,917	65%
New Jersey	—	14,588	19,004	—
New Mexico	1,290	3,272	4,092	217%
New York	49,779	66,924	74,626	50%
North Carolina	4,111	12,643	20,441	397%
North Dakota	468	441	424	–9%
Ohio	7,800	19,153	28,549	266%
Oklahoma	1,208	7,273	14,744	1,121%
Oregon	1,120	2,136	2,551	128%
Pennsylvania	12,288	23,101	27,604	125%
Rhode Island	896	2,634	3,331	272%

Figure A.4 Number of Home Health Employees *(continued)*

	1990	1994	1997	Percent Change 1990-1997
South Carolina	914	2,673	3,916	328%
South Dakota	—	—	367	—
Tennessee	7,333	16,408	15,343	109%
Texas	53,201	87,051	134,115	152%
Utah	934	2,837	3,779	305%
Vermont	960	1,930	2,602	171%
Virginia	2,505	10,204	14,288	470%
Washington	3,966	5,754	5,171	30%
West Virginia	870	2,905	3,503	303%
Wisconsin	6,059	7,426	8,290	37%
Wyoming	242	402	622	157%
United States	282,046	555,554	708,821	151%

Note: "—" means data are not available.

Source: HCFA/Office of Strategic Planning (OSP) analysis of sample data files used by OSP in its publication series.

A Medicare Home Health Primer

Section 6

6. A Medicare Home Health Primer

Home health has been a part of Medicare since the program's inception in 1965. Under the benefit today, services such as skilled nursing care, physical therapy, and personal care[1] are furnished at home to Medicare beneficiaries who meet certain eligibility criteria as required by law. Almost 11 percent, or 3.6 million, of Medicare's 33 million beneficiaries in the traditional fee-for-service program received home health services in 1997. An unknown number of the nearly 6 million Medicare+Choice beneficiaries also receive home health.

Current Medicare Home Health Services

Medicare covers home health services for beneficiaries who meet certain eligibility criteria. Covered services include:

- part-time or intermittent[2] skilled nursing and home health aide services,
- physical, speech, and occupational therapy,
- medical social services (such as patient counseling),
- medical supplies, and durable medical equipment.

There is no beneficiary cost-sharing for these services, except for durable medical equipment, which is subject to 20 percent co-insurance.

Home health services must be furnished by, or under arrangements by, Medicare-certified home health agencies. These providers must undergo certification surveys to ensure they meet the home health conditions of participation (CoPs). The CoPs are designed to ensure agencies focus on delivering high-quality care and improving patient outcomes.

[1] Personal care includes help with bathing and dressing. Home health aides provide personal care related to the treatment of the beneficiary's illness or injury.

[2] Part-time or intermittent means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week. (Or, subject to case-by-case review of the need for care, less than 8 hours each day and 35 or fewer hours per week.)

Eligibility Requirements

To qualify for Medicare home health, a beneficiary must be:

- physician-certified as homebound,
- in need of intermittent skilled nursing care, or physical or speech therapy,[3]
- under a physician's care who certifies that care in the home is necessary. The physician also must establish and periodically review the patient's plan of care.

A beneficiary who only requires personal care, and has no skilled medical care needs, does not qualify for the benefit.

Program Administration

The Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (HHS) administers the Medicare program. HCFA contracts with public or private organizations to serve as fiscal intermediaries between the government and Medicare providers, including home health agencies. The intermediaries process claims submitted by agencies, make payment, serve as a communication channel between providers and HCFA, and apply payment safeguards to prevent program abuse.

A Brief History of Medicare Home Health

The Medicare home health benefit and its use have changed dramatically since 1965. Over time, legislation, a landmark court case, patient demographics, and changes in the delivery of health services have altered the way beneficiaries use Medicare home health.

[3] Once a beneficiary is already receiving home health, s/he can continue to qualify for the benefit by having an ongoing need for occupational therapy.

1965

In 1965 Congress enacted a home health benefit within the Medicare program, under Title XVIII of the Social Security Act. Home health was conceived as a recuperative, short-term benefit, and based on a medical model of care. Allowing patients to recover at home was considered a less expensive alternative to institutional care. To qualify for Medicare home health, individuals were required to need skilled medical care, a stipulation that continues today.

The benefit was separated into Medicare Part A "post-hospital home health services," and Part B "home health services." Part A home health was only available to beneficiaries who had a recent hospital or nursing home stay. The number of Part A home health visits was limited to 100 per year, and beneficiary cost-sharing did not apply.

Part B home health did not require an institutional stay. If enrolled in Medicare Part B, beneficiaries without a hospital or nursing home stay could receive home health services. Part B also was limited to 100 visits per year. For those beneficiaries who exhausted all of their Part A visits and carried Part B insurance, an additional 100 visits were available under Part B.

Home health under Part B was subject to cost sharing. The $50 Part B deductible in 1966 and 20 percent coinsurance applied to Part B visits. In addition, home health expenditures under Medicare Part B were included in the calculation of the Part B premium.

Reimbursement for Medicare services, including home health, was based on "reasonable costs." Among other factors, reasonable costs took into account the provider's direct and indirect costs for delivering care.

In 1965, the home health industry largely consisted of non-profit providers. In order to participate in the Medicare program, proprietary home health agencies were required to be licensed by the states. Because few states licensed home health agencies, many proprietary agencies were excluded from Medicare.

1972

The first major change to the home health benefit occurred with the 1972 amendments to the Social Security Act. The 20 percent co-insurance for Part B home health was eliminated.

The law also made significant changes to the entire Medicare program, including: the extension of Medicare coverage to individuals under 65 years of age with qualifying disabilities or chronic renal disease, and the authority to impose cost limits on Medicare services, including home health. With this authority, Medicare published cost limits on home health visits for the first time in 1979.

1980

By 1980, the institutional requirement for Part A home health and the 100 visit limits under Part A and Part B were viewed by some members of Congress as too restrictive. These requirements were thought to force some beneficiaries — those who exceeded the 200 visit limit or who did not carry Part B coverage — to seek more expensive institutional care.

The Omnibus Budget Reconciliation Act of 1980 (OBRA) thus eliminated the 100 visit limits for both Part A and Part B. It also removed the distinction between Part A and Part B home health. Consequently, the Part A trust fund began financing the majority of home health services. OBRA also eliminated the Part B deductible for home health. In addition, restrictions on for-profit home health agencies' ability to participate in Medicare were abolished.

For eligible beneficiaries, OBRA created virtually an unlimited home health benefit. The OBRA changes also exempted beneficiaries from almost all home health cost-sharing. Subsequent to these changes, home health use and spending accelerated. From 1980 to 1985, the proportion of Medicare beneficiaries receiving home health rose from about 3.4 percent to 5.1 percent. Home health expenditures, over this period, nearly doubled from $1.5 billion to $2.7 billion, in real terms (1997 dollars).

1989

The rapid home health spending growth prompted the Health Care Financing Administration (HCFA) to tighten interpretation of coverage criteria. The stricter interpretation eventually led to a class action suit, *Duggan v. Bowen*, filed by a coalition of beneficiaries and providers in 1987. The plaintiffs charged that Medicare's interpretation of the statutory phrase "part-time or intermittent" was too narrow, leading to the denial of care for eligible beneficiaries. The Court agreed.

Under the *Duggan v. Bowen* settlement in 1989, the Medicare Home Health Agency Manual was revised to clarify coverage criteria and to reflect the Court's decision. These manual revisions essentially broadened the coverage criteria, allowing more beneficiaries to qualify for home health, and more visits per individual.

Medical review policy also changed after *Duggan v. Bowen*. Before the lawsuit, a fiscal intermediary could deny visits over the number it deemed medically necessary. For example, if a home health agency claimed 60 visits, but the intermediary determined that only 50 were necessary to adequately treat the patient, 10 visits were denied payment. The intermediary was not required to review each visit separately for medical necessity. Since the lawsuit, in order to deny a visit, intermediaries must determine that a particular visit was not medically necessary at the time it was ordered. This increased the costs of medical review significantly.

Once again, home health use and spending surged. The percent of beneficiaries receiving home health increased in every state, from 1990 to 1994. Data from 1990 to 1997 show that the average payment per visit grew only slightly, but the average annual number of visits per home health user more than doubled from 36 to 73. Home health users went from 5.8 percent to almost 10.8 percent of the Medicare population. Total home health expenditures rose from $4.6 billion in 1990 to $16.7 billion in 1997 in real terms (1997 dollars).

As the Medicare population ages, many beneficiaries need the types of services provided by home health aides. The Medicare benefit became an attractive and available resource to fulfill those needs. A greater number of beneficiaries living longer with chronic illnesses and functional limitations contributed to the use of home health in this manner. In addition, from 1990 to 1997, the number of home health agencies grew from 5,708 to 10,807.

1995

The rapid growth in home health drew attention and gave rise to concerns about fraud. The Department of Health and Human Services' (HHS) Inspector General (IG) and the General Accounting Office (GAO) launched investigations into the activities of some home health agencies. As a result of the investigations, the GAO and IG identified various instances of inappropriate payments to agencies and cases of fraudulent behavior.[4]

Given the concerns about waste, fraud and abuse in home health and other areas of Medicare, the Administration launched a comprehensive anti-fraud initiative, Operation Restore Trust (ORT) in 1995.

1997

The Balanced Budget Act of 1997 (BBA) enacted sweeping changes to the Medicare program, including the home health benefit. The changes in the law were designed to slow the rate of expenditure growth, provide incentives for efficiency in the delivery of care and ensure that Medicare pays appropriately for services.

The BBA created an interim payment system (IPS) for home health until a prospective payment system is established (See narrative under 1998). It creates incentives to return home health utilization to federal fiscal year 1994 levels—the base year for one of the interim payment system's two cost limits. IPS pays agencies the lowest of:

[4] HHS/Office of Inspector General. OEI-04-93-00260 *Variation Among Home Health Agencies in Medicare Payments for Home Health Services.* July 1995.

General Accounting Office. GAO/OSI-95-17 *Medicare: Allegations Against ABC Home Health Care.* July 1995.

1) an agency's actual cost, or

2) an aggregate per visit cost limit, set at 105 percent of the median cost for agencies nationwide (increased to 106 percent by law in 1998), or

3) an aggregate per beneficiary cost limit.

The per visit limit is designed to encourage agencies to provide services efficiently during each visit. The aggregate per beneficiary limit encourages agencies to plan and deliver care more effectively by consolidating visits and eliminating unnecessary visits.

Depending on the age of the agency, the aggregate per beneficiary limit is primarily based on an agency's costs for serving patients in fiscal year 1994, or on the national median of the aggregate per beneficiary limits. This limit is adjusted further by blending an agency's own costs with costs from other agencies in the same census region.

The cost limits under IPS are based on an agency's total costs, not the costs associated with individual patients. Home health agencies are thus allowed to balance the costs of caring for low-need patients against the costs for high-need patients. The IPS cost limits do not cap the number of visits to any one patient, nor do they limit the amount of money an agency can spend in caring for any one patient. However, because IPS aims to reduce the rapid growth in home health expenditures and the unexplained, variation in utilization, it creates incentives for agencies to reduce unnecessary expenditures and operate as efficiently as possible.

Another provision in the BBA was designed to ensure that beneficiaries who obtain Medicare home health are in need of skilled medical care. Under the law, venipuncture for collecting a blood specimen alone can no longer qualify an individual for home health. Some beneficiaries were qualifying for home health based solely on their need for periodic blood draws. Often, these individuals subsequently received multiple home health aide visits for personal care. This provision may have reduced the ability to use Medicare home health as a resource for those with long-term care needs.

The BBA also modified the way home health benefits are paid from the Part A and Part B trust funds (when an individual is entitled to both Part A and B coverage.) The financing of some home health visits is being transferred from the Part A to the Part B trust fund over 6 years. Similar to the original 1965 law, Medicare Part A covers the first 100 visits following a 3-day hospital stay or a skilled nursing facility stay. Part B covers all other visits. In effect, the BBA revives the concept of post-acute and non post-acute home health services, at least from a financing perspective. Although the financing is gradually transferring over 6 years, the cost of the Part B visits formerly under Part A is being phased in to the Part B premium over 7 years.

1998

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 revised the interim payment system created under the BBA. The per visit and the per beneficiary cost limits on home health visits were increased moderately. The law also sought to alleviate some of the regional variation in Medicare reimbursement under the interim payment system. The implementation of a prospective payment system was delayed for one year, until October 1, 2000. Under this system, home health agencies will be paid a fixed amount for each patient for each 60-day episode of care, adjusted for the severity of the patient's condition and geographical differences in wages.

Data Sources

NOTE

Note on Data Sources

Medicare Current Beneficiary Survey Data (MCBS)

Data on Medicare home health users' and non-users' income, living arrangements, functional impairments, types of health insurance and out-of-pocket costs are from the Medicare Current Beneficiary Survey. MCBS is a continuous survey of a nationally representative sample of approximately 15,000 aged and disabled Medicare beneficiaries. Beneficiary participation in the MCBS is voluntary. A key feature of the survey is its longitudinal design, following sample individuals over a period of four years. Each sample person voluntarily agrees to an interview three times a year, regardless of whether he or she resides in the community or a facility, or transitions between community and facility settings. The MCBS is sponsored by the Health Care Financing Administration (HCFA). Detailed information on MCBS is available at the HCFA website **http://www.hcfa.gov/mcbs**

For the purposes of this chart book, Medicare beneficiaries have been categorized as follows: home health users and non-users are individuals who resided in the community during the year. Home health users and non-users also include individuals who lived in both the community and in a facility (such as a nursing home) during the year. Individuals who used Medicare home health any time within the year are home health users. Non-users are individuals who did not receive Medicare home health during the year.

HCFA/Office of Strategic Planning Sample Data Files

In general, data on Medicare home health utilization and spending are derived from the home health claims for a 40-percent sample of Medicare beneficiaries. The one exception is the data used to develop Figure 3.6 in the Home Health and Medicare Spending section. The data in Figure 3.6 are derived from all Medicare claims — not just home health — for a 5-percent sample of Medicare beneficiaries. Using the 5-percent sample of all Medicare claims is necessary to calculate average Medicare payments for all services provided to home health users and non-users. Both the 40-percent and 5-percent samples have been determined to be statistically valid.

Department of Labor, Bureau of Labor Statistics Data

The Current Employment Statistics (CES) Survey is a monthly survey of business establishments, including freestanding home health agencies (agencies that are not associated with a hospital or nursing home). The survey provides estimates of employment, hours worked, and earnings data by industry for the entire country, all States, and most major metropolitan areas.

The CES Survey is a Federal-State cooperative endeavor. State employment security agencies prepare the data using concepts, definitions, and technical procedures prescribed by the Bureau of Labor Statistics. Employment data refer to persons on business establishment payrolls who receive pay for any part of the pay period which includes the 12th of the month. Persons are counted at their place of work rather than at their place of residence; those appearing on more than one payroll are counted on each payroll. Establishments are classified in an industry on the basis of their principal product or activity, in accordance with the 1987 Standard Industrial Classification Manual. CES Survey data are available at **http://www.bls.gov**